CUSTOMERSERVICE@HOPEDME.COM
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# PHYSICIAN ORDER FORM: INTERMITTENT CATHETERS

## REFERRAL INFORMATION

YOUR NAME________________________________ OFFICE/FACILITY________________________

TEL________________________FAX______________________EMAIL________________________

## PATIENT INFORMATION

➔**PATIENT NAME**________________________________ ➔**INSURANCE ID #**______________________

➔**DIAGNOSIS(ES)** ❑URINARY RETENTION (R33.9) ❑URINARY INCONTINENCE (R32)

❑ADDITIONAL DX ______________________________________________

ADDRESS ________________________________ CITY, STATE, ZIP ________________________

DOB__________________ SS#__________________________ TEL__________________________

PRIMARY INS________________________________ TEL____________________________________

## PRESCRIPTION

➔**FREQUENCY** PRESCRIBED CATHETERIZATIONS PER DAY ______(X 30 =) ➔**QUANTITY PER MONTH** ______

➔**FRENCH SIZE** ______ FR ➔**LENGTH OF NEED** _____ MONTHS (99=LIFETIME)

➔**CATHETER TYPE**

❑STRAIGHT TIP URINARY CATHETERS (A4351) *OR* ❑COUDE TIP URINARY CATHETERS (A4352)

❑W/ LUBRICANT TUBE (4 OZ / 4 UNITS) (A4402)

❑W/ LUBRICANT PACKET (1 PER EACH CATHETERIZATION)(A4332)

❑STRAIGHT TIP URINARY CATHETERS W/ STERILE INSERTION SUPPLIES (A4353)

❑COUDE TIP URINARY CATHETERS W/ STERILE INSERTION SUPPLIES (A4353)

➔ **REFILLS** REFILL MONTHLY AT PRESCRIBED QUANTITIES FOR LENGTH OF NEED? ❑YES ❑NO

SPECIAL INSTRUCTIONS / OTHER ITEMS:

## PHYSICIAN

➔**PHYSICIAN NAME**______________________ ➔**NPI**__________________ ➔**ORDER DATE** __________

➔**PHYSICIAN SIGNATURE**______________________________________ ➔**SIGNATURE DATE**__________

****ATTACH CHART NOTES AND PATIENT DEMOGRAPHICS****