



## Urological Supply Order Form

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_ Order Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Facility Contact: \_\_\_\_\_

ICD-10 Diagnosis Code: \_\_\_\_\_

Does patient have a latex allergy?    Yes    No    (If Yes, additional documentation is required.)

Length of Need (Please circle):    Lifetime    99 months    Other \_\_\_\_\_

Number of Refills: \_\_\_\_\_

**\*PLEASE CIRCLE BELOW\***

Intermittent Catheter			Male Externals	Drainage Bags	Indwelling Catheter	
TYPE	SIZE	LENGTH	SIZE		BALLOON	SIZE
Straight	5 Fr    12 Fr	Pediatric 10" long	Small:    23mm	500ml Leg Bag w/tubing straps	5cc    10cc	12 Fr    20 Fr
Coude	6 Fr    14 Fr	Adult 16" long	Med:        28mm	1,000ml Leg Bag w/tubing straps	30cc	14 Fr    22 Fr
Closed System	8 Fr    16 Fr	Female 6" long	Intermed: 31mm	2 Bedside Drainage Bags	Other: _____	16 Fr    24 Fr
Red Rubber	10 Fr    18 Fr		Large:      35mm	Other:		18 Fr    26 Fr
			X-Large: 40mm			
Frequency of use:						
Quantity/day,wk,mnth:						

Other Items	Size/Type	Frequency of Use	Quantity/day,wk,mnth
Insert Tray	N/A		
Leg Strap	N/A		

**Additional Notes:**

---

\*Additional documentation support is required for: Female/Male Coude, Sterile technique (e.g. actual lab test results of UTI) and when Medicare's usual maximum supply of quantity is exceeded.

By signing below, I authorize the use of this document as an order and I certify that the above prescribed supplies are medically necessary and reasonable.

Physician's Printed Name: _____		NPI #: _____	
Physician's Signature: _____		Date: _____	
Substitutions Permitted:      Yes      No			

Has this patient been in the Hospital within the past 30 days?  
 Has this patient been seen by a Home Health Agency or Hospice Service in the past 30 days? If yes, please list the name of the facility, their address and the discharge date.

YES    NO

\_\_\_\_\_