GROVE MEDICAL, INC
1089 PARK WEST BLVD
GREENVILLE, SC 29611
864-269-0283 (Phone)
864-272-1569 (Fax)

UROLOGY SUPPLY ORDER FORM

(Please include the Patient Information Sheet with the order form)

PATIENT'S NAME: _____ **ORDER DATE:** _____

PATIENT'S DOB:_____

FACILITY NAME: _____

FACILITY TELEPHONE #: _____ **FACILITY FAX#:** _____

Diagnosis/ICD-9 Code:
___ 340 Multiple Sclerosis ___ 344 Quadriplegia ___344.1 Paraplegia ___ 596.54 Neurogenic Bladder ___ 599.60 Urinary Obstruction NOS
___ 741.90 Spina Bifida w/o mention ___ 788.20 Urinary Retention unspecified ___ 788.30 Urinary Incontinence NOS
___ V44.6 Urostomy ____ 625.6 Stress Incontinence Female ___ Other: _____

Does patient have a latex allergy? Yes No Length of Need: _____ **or Number of Refills:** _____

UROLOGY SUPPLIES NEEDED

Intermittent Catheters: (Please circle below) **Male Externals** **Drainage Bags** **Foley Catheter**

Type	Size		Length	Size		Type	Size	
Straight	5 Fr	12 Fr	Pediatric(10" long"	Small: 23mm	500ml Leg Bag w/tubing straps	5cc	5 Fr	12 Fr
Coude	6 Fr	14 Fr	Adult (16" long)	Med: 28mm	1,000ml Leg Bag w/tubing straps	30cc	6 Fr	14 Fr
Closed System	8 Fr	16 Fr	Female (6" long)	Intermed: 31mm	2 Bedside Drainage Bags		8 Fr	16 Fr
Red Rubber	10 Fr	18 Fr		Large: 35mm	Other:		10 Fr	18 Fr
				X-Large: 40mm				
Frequency of use:								
Quantity/day,wk,mnth:								

Other Items	Size/Type	Frequency of Use	Quantity/day,wk,mnth

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

Physician's Printed Name:	NPI #
Physician's Signature:	Date:

Is this patient currently being seen by a Hospice, Home Health Agency or in the Hospital? If yes, please list the name of the facility, their address and the discharge date.

YES NO

_____

_____