UROLOGICAL ORDER FORM

Patient Name: _____DOB:_____

Address: _____

_____Phone Number_____

Insurance _____

Diagnosis: _____DATE:_____

Physician Name: _____

Address:_____

Phone Number:_____ Fax Number: _____

NPI: _____

Physician Signature_____ Date: _____

Intermittent Catheter Details Section:

1. What type of catheter does the patient need?
   - Sterile Intermittent Catheters
   - Sterile "Closed Touchless"
2. Does the patient need a straight or coude' tip?
   - Straight
   - Coude'
3. What French (FR) size does the patient need?
   6 8 10 12 14
   16 18 20 22 24
4. Length of the catheter:
   - 6" (typical for female catheter)
   - 16" (typical for male catheter)
   - _____ other length
5. Brands:
   - Bardia
   - Cure
   - Hollister
6. What frequency should the patient catharize?
   _____ (times per) Day Week Month
7. Total quantity of catheters requested every 30 days
   _____
8. Surgical Lubricant (please choose)
   1tube per month Yes____ No____
9. Authorized Refills:
   _____

*Bedside Urinary Drainage Bag (2 per month) Yes_____ No_____
*Urinary Drainage Leg Bag (2per month) Yes_____ No_____

Additional Notes:
_____
_____
_____

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