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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