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# UROLOGY ORDER FORM

***Please attach face sheet w/ patient demographics & insurance info***

## PATIENT INFORMATION

Patient Name: ____________________

DOB: ______ /______ /________ Start Date: ______ /______ /________ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: ____________ Does the patient have a latex allergy? ☐ YES ☐ No

Has the patient had two or more Urinary Tract Infections (UTI) in the previous year? *(If yes, please attach supporting labs)* ☐ YES ☐ No

Primary Diagnosis- ICD-10 Code: ____________ Secondary Diagnosis- ICD-10 Code: ____________

Length of Need: ____________ Months

## PRODUCT SELECTION

| INTERMITTENT CATHETERS | | | MALE EXTERNAL CATHETERS | FOLEY CATHETER |
|---|---|---|---|---|
| *Type* | *Size* | *Length* | *Size* | *Size* |
| ☐ Straight | ☐ 6FR | ☐ 6" (female) | ☐ SMALL ________mm | ☐ 5cc |
| ☐ Hydrophilic Straight | ☐ 8FR | ☐ 10" (pediatric) | ☐ MEDIUM ________mm | ☐ 10cc |
| ☐ Coude (medical records required) | ☐ 10FR | ☐ 16" (adult) | ☐ LARGE ________mm | ☐ 30cc |
| ☐ Hydrophilic Coude | ☐ 12FR | | ☐ X-LARGE ________mm | |
| ☐ Closed System (medical records required) | ☐ 14FR | ☐ Lubricant: | | French Size: ________ |
| ☐ Red Rubber | ☐ 16FR | ind. packets | Qty: ________ | Qty: ________ |
| | ☐ 18FR | tube | | ☐ Latex ☐ Silicone |
| | ☐ Other | Qty: ________ | | |

BRAND: ____________________ Item#: ____________

FREQUENCY: ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ 5x/day ☐ 6x/day ☐ Other____________ Qty: ________

## ACCESSORIES

| | | |
|---|---|---|
| ☐ Foley Insertion Tray | | Qty: ________ |
| ☐ Foley Irrigation Tray | | Qty: ________ |
| ☐ Intermittent Catheter Tray | | Qty: ________ |
| ☐ Leg Bag | ☐ 500ml<br>☐ 1000ml | Qty: ________ |
| ☐ Bedside Bag | ☐ 2000ml<br>☐ 4000ml | Qty: ________ |

☐ Leg Strap: _____medium _____large Qty: ________

☐ Extension Tubing Qty: ________

☐ Syringe Qty: ________

☐ Appliance cleaner Qty: ________

☐ Tape ☐ 1" ☐ 2" ☐ 3" Qty: ________
☐ Plastic (waterproof) ☐ Cloth (waterproof) ☐ Paper

☐ Anchoring Device Qty: ________

☐ Other____________ Qty: ________

## REFERRAL INFORMATION

**Ref #:** ____________

Practice Name: ____________ Fax: ____________

Office Address: ____________ Email: ____________

Phone: ____________ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: ____________

Physician Name: ____________ NPI#: ____________ Phone: (_______)_______-_________ Ext. _______

Physician Signature: ____________ Date: ______ /______ /________

*I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.*

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: ____________ Date: ______ /______ /________

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