PHONE: 1.888.248.1975 FAX: 1.888.248.2026
EMAIL: connect@chcsolutions.com

CONTINUUM CONNECT 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 ☐ 1000ml	Qty: __________
☐ Bedside Bag	☐ 2000ml ☐ 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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