HealthSource
a CHC Solutions Company

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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

Type	*Size*	*Length*
☐ Straight	☐ 6FR	☐ 6" (female)
☐ Hydrophilic Straight	☐ 8FR	☐ 10" (pediatric)
☐ Coude (medical records required)	☐ 10FR	☐ 16" (adult)
☐ Hydrophilic Coude	☐ 12FR	
☐ Closed System (medical records required)	☐ 14FR	☐ Lubricant:
☐ Red Rubber	☐ 16FR	☐ ind. packets
	☐ 18FR	☐ tube
	☐ Other	Qty: _____

MALE EXTERNAL CATHETERS

Size

☐ SMALL _____mm
☐ MEDIUM _____mm
☐ LARGE _____mm
☐ X-LARGE _____mm

Qty: _____

FOLEY CATHETER

Size

☐ 5cc
☐ 10cc
☐ 30cc

French Size: _____
Qty: _____
☐ Latex ☐ Silicone

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: _____ /_____ /_____