



Toll Free: 1-844-693-6316
Fax Order To: 844-972-1537
Email Order To: orders@promed-dme.com

Urology Physicians Order Form: Chart notes must include the need for the supplies ordered

Rep: _____

Referral Source: _____

Patient Name: _____

Patient DOB: _____

Patient Phone: _____

Patient Email: _____

Insurance Policy: _____

ID#: _____

DIAGNOSIS (Check appropriate diagnosis below)

<input type="checkbox"/> R33.9 - Urinary Retention	<input type="checkbox"/> R32 - Urinary Incontinence	<input type="checkbox"/> Other Primary Diagnosis: _____
<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> UTI History <small>(Please fax a copy of U/A and Culture with this form)</small>	<input type="checkbox"/> Duration of Need: _____ months <small>(1-99 months; 99=lifetime)</small>

CATHETER PRODUCT TYPES (HCPCS)

<input type="checkbox"/> Straight Catheter (A4351) w/ Lubricant	<input type="checkbox"/> 8FR <input type="checkbox"/> 10FR <input type="checkbox"/> 12FR <input type="checkbox"/> 14FR <input type="checkbox"/> 16FR <input type="checkbox"/> 18FR <input type="checkbox"/> Other: ____
<input type="checkbox"/> Catheter Kit (A4353) w/ Insertion Supplies	
<input type="checkbox"/> Coude Catheter (A4352) w/ Lubricant	
<input type="checkbox"/> Foley Catheter (A4338)	
<input type="checkbox"/> Foley Catheter (A4340) Coude	
<input type="checkbox"/> Foley Catheter (A4344) Silicone	
<input type="checkbox"/> Insertion Tray (A4310)	

FREQUENCY

<input type="checkbox"/> 1 per day/ 30 per month	<input type="checkbox"/> 5 per day/ 150 per month
<input type="checkbox"/> 2 per day/ 60 per month	<input type="checkbox"/> 6 per day/ 180 per month
<input type="checkbox"/> 3 per day/ 90 per month	<input type="checkbox"/> 7 per day/ 210 per month
<input type="checkbox"/> 4 per day/ 120 per month	<input type="checkbox"/> Other ____ per day ____ per month

OTHER PRODUCT TYPES, SIZES and QUANTITIES

<input type="checkbox"/> Male External (A4349) Size: _____ mm	<input type="checkbox"/> 35 per month	<input type="checkbox"/> Other ____ per day
<input type="checkbox"/> Leg Bags (A4358)	<input type="checkbox"/> 2 per month	<input type="checkbox"/> Other ____ per day
<input type="checkbox"/> Drainage Bags (A4357) Other: _____	<input type="checkbox"/> 2 per month	<input type="checkbox"/> Other ____ per day
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Quantity Per Month: _____	

PRESCRIBING PHYSICIAN INFORMATION

Name & Credentials _____

NPI _____

Signature _____

Signature Date _____

(Stamped signature not accepted)

Phone _____

Fax _____