Continuum
a CHC Solutions Company

PHONE: 1.844.317.9620 FAX: 1.844.317.9378
EMAIL: orders@chcsolutions.com

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

Emergency Contact Name/Phone Number: _____

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

Length of Need: _____ Months

PRODUCT SELECTION

INTERMITTENT CATHETERS/TRAYS

Type: ☐ Red Rubber ☐ Coude **(medical records required)** ☐ Straight ☐ Closed System (**medical records required**)
☐ Hydrophilic Coude ☐ Hydrophilic Straight

Size: ☐ 6FR ☐ 8FR ☐ 10FR ☐ 12FR ☐ 14FR ☐ 16FR ☐ 18FR ☐ Other

Length: ☐ 6" (female) ☐ 10" (pediatric) ☐ 16" (adult) ☐ Intermittent Catheter Tray

FREQUENCY: ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ 5x/day ☐ 6x/day ☐ Other:_____ Qty:_____

MALE EXTERNAL CATHETERS

Size: _____mm Qty: _____

FOLEY CATHETER/INSERTION TRAYS

Size: ☐ 10cc ☐ 30cc

French Size: _____ Qty: _____

☐ Latex ☐ Silicone ☐ Insertion Tray

ACCESSORIES

☐ Irrigation Tray Qty: _____
☐ Saline (100ml) Qty: _____
Lubricant: ☐ Indiv. Packets ☐ Tube Qty:_____
☐ Bedside Bag (2000ml) Qty: _____
☐ Leg Bag ☐ 500ml ☐ 1000ml Qty: _____

☐ Leg Strap Qty: _____
☐ Appliance Cleaner Qty: _____
☐ AMD Split Gauze 4x4 (2 per pack) Qty: _____
☐ Waterproof Tape ☐ 1" ☐ 2" ☐ 4" Qty: _____
☐ 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: _____/_____/_____