



PHONE: 1.888.248.1975 FAX: 1.888.248.2026

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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
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: \_\_\_\_\_  Leg Strap Qty: \_\_\_\_\_
 Saline (100ml) Qty: \_\_\_\_\_  Appliance Cleaner Qty: \_\_\_\_\_
Lubricant:  Individ. Packets  Tube Qty: \_\_\_\_\_  AMD Split Gauze 4x4 (2 per pack) Qty: \_\_\_\_\_
 Bedside Bag (2000ml) Qty: \_\_\_\_\_  Waterproof Tape  1"  2"  4" Qty: \_\_\_\_\_
 Leg Bag  500ml  1000ml 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: \_\_\_\_/\_\_\_\_/\_\_\_\_