

**\*\*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  Coude  Silastic  Insertion Tray

**ACCESSORIES**

<input type="checkbox"/> Irrigation Tray Qty: _____	<input type="checkbox"/> Leg Strap Qty: _____
<input type="checkbox"/> Saline (100ml) Qty: _____	<input type="checkbox"/> Appliance Cleaner Qty: _____
Lubricant: <input type="checkbox"/> Individ. Packets <input type="checkbox"/> Tube Qty: _____	<input type="checkbox"/> AMD Split Gauze 4x4 (2 per pack) Qty: _____
<input type="checkbox"/> Bedside Bag (2000ml) Qty: _____	<input type="checkbox"/> Waterproof Tape <input type="checkbox"/> 1" <input type="checkbox"/> 2" <input type="checkbox"/> 4" Qty: _____
<input type="checkbox"/> Leg Bag <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml Qty: _____	<input type="checkbox"/> Anchoring Device Qty: _____
	<input type="checkbox"/> 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: \_\_\_\_/\_\_\_\_/\_\_\_\_