



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

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, 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: ____/____/____

Call 1.888.248.1975 or visit www.connectchc.com for additional information.