



5493 Merrick Road * Massapequa, NY 11758 * (516) 216-1707

Fax to: (516) 452-5095
for fast processing and discrete delivery!
(Please include patient demographics)

Intermittent Catheter Detailed Written Order

Order Date: ____ / ____ / ____

Patient Name: _____ DOB: ____ / ____ / ____ Phone: _____ M F

1° Diagnosis: R33.9 Retention of Urine R39.14 Incomplete Bladder Emptying R32 Urinary Incontinence

2° Diagnosis N31.9 Neurogenic Bladder G35 Multiple Sclerosis G82.50 Quadriplegia
 G82.20 Paraplegia N40.1 Enlarged Prostate with LUTS N35.9 Urethral Stricture Unspec.
 C61 Prostate Cancer C67.9 Bladder Cancer

Intermittent Catheter:

Manufacturer: No Preference _____

French Size: 8 Fr 10 Fr 12Fr 14Fr 16 Fr 18Fr 20Fr 22Fr.

Length: 6-7.5" Female 16" Male 10" Pediatric 25" Extra Long

Type of Catheter: Straight Tip Coude' Tip

Lubricant (3 gram packet) (Medicare allows one packet per catheterization)

Hydrophilic

Closed System Sterile Kit (Specific documentation is required in the medical record to qualify for this type of catheter)

Frequency/Quantity/Length of Need:

**Catheterize _____ times per day. **Quantity _____ / mo. ** Length of need _____ Months/Refills

3 Month Supply OK? Y N

****ATTENTION PHYSICIANS:** Please clearly document in the patient's medical record the number of times per day that you are instructing them to perform self- catheterization. Just listing that value on this order form is not sufficient. If your male patient is using a coude' tip catheter, you must document why they need a coude' instead of a straight tip.

Additional Supplies/Instructions

Physician's Name: _____ NPI: _____

Physician's Signature: _____ Date: ____ / ____ / ____