



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

Fax to: (516) 452-5095

for fast processing and discrete delivery!
(Please include patient demographics)

Urological Supply 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 G82.50 Quadriplegia G82.20 Paraplegia C61 Prostate Cancer
 N40.1 Enlarged Prostrate with LUTS N35.9 Urethral Stricture Unspec. C67.9 Bladder Cancer

Intermittent Catheter - (Medicare allows up to 200 catheters per month if medically necessary)

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" XL Male

Type of Catheter: Straight Tip Coude' Tapered Tip Coude' Olive Tip Coude' Tiemann Tip

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

Hydrophilic Pre- Lubricated Closed System Sterile Kit (Specific Medical Necessity Required)

Frequency/Quantity/Length of Need: (Medicare allows 1 sterile catheter for each medically necessary catheterization)

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

****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 needing a coude' catheter, please document in your notes the medical necessity.**

Foley Catheter - (Medicare allows 1 per month) 5cc 30cc 2 way **Length of need _____ Months/Refills

Straight Tip (A4338) Coude Tip (A4340) Foley Insertion Tray Kit (Sterile) (A4310)

French Size: 8 Fr 10 Fr 12Fr 14Fr 16 Fr 18Fr 20Fr 22Fr 24Fr

External Condom Catheter - (Medicare allows up to 35 per month) Qty. _____ /mo. Size (Penis Diameter): _____ mm

Drainage Bags - (Medicare allows 2 leg bags and 2 bedside bags per month)

500-600 ml Leg Drainage Bag with tubing, straps (A4358) Qty. _____ /mo.

1000 ml Leg Drainage Bag with tubing, straps (A4358) Qty. _____ /mo.

2000 ml Bedside Drainage Bag (A4357) Qty. _____ /mo.

Physician's Name: _____ NPI: _____

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