548 New London Tpke
Glastonbury, CT 06033
P 860-633-1882
F 860-812-2398

Catheter Order Form

****PLEASE INCLUDE PATIENT DEMOGRAPHICS****
****FOR MEDICARE PATIENTS, INCLUDE PROGRESS NOTES****

Patient Information:
Patient Name: ____ DOB: ___________
Patient Address: ____
Patient Phone: ___________________________ Alt Phone: ___________________________

Diagnosis:
☐ Retention of Urine (788.20/R33.9)
☐ Incomplete Bladder Emptying (788.21/R39.14)
☐ Other Specified Retention of Urine (788.29/R33.8)
☐ Urinary Incontinence (788.30/R32)
☐ Urge Incontinence (788.31/N39.41)
☐ Other Diagnosis ______________

Order Date ____________________
Length of Need…………………………………… ☐ 12(One Year
Does Patient Have Permanent Urinary Incontinence or Retention? ☐ Yes ☐ No
(Note: Permanency is defined as a condition that is expected to last greater than 90 days)

Please Check Desired Product and Indicate Size & Quantity in Box Provided

Supplies		**Size**	**Quantity to Dispense**
Straight Intermittent (A4351)	☐	Fr ________	_____ Per month
Coude Intermittent (A4352) *	☐	Fr ________	_____ Per month
Closed System (A4353)	☐	Fr ________	_____ Per month
External Cath (A4349)	☐	23 - 28- 32-36	_____ Per Month
Lubricant Packet (A4332) Lubricant Tube (A4402)	☐		_____ Per month
Overnight Drain Bag (A4357)	☐		_____ Per month
Leg Bag (A4358)	☐		_____ Per month

*When a Coude tip catheter is used there must be documentation in the beneficiary's medical record of the medical necessity for that catheter. An example would be the inability to catheterize with a straight tip catheter.

Physician Information:

Physician Name: _______________________________ NPI: ____________________________

Office Address: ______________________________ City, State, Zip: _____________________

Phone: ______________________________ Fax: ___________________________________

Physician Signature____ Date: __________
(Attach Physician Notes)