HOME CARE DELIVERED®
Your Trusted Partner for Medical Supplies

Phone: **(866) 332-4193**
Fax: **(888) 565-4411**
Email: **Refer@HCD.com**
Online: **HCD.com/Refer**

Urological Supply Order Form

ATTENTION CLINICIANS: Please clearly document in your chart the number of times per day that the patient performs self-catheterization. Just listing that value on the prescription or on this form is not sufficient. In the case of an audit, Medicare would look for documentation in the patient's medical record.

ORDER DATE: _____

Patient name: _____

Date of birth: _____

Length of need: 12 months unless otherwise noted here: _____ months

Primary Diagnosis:
- ☐ Retention of Urine R33.9
- ☐ Urinary Incontinence R32

Secondary Diagnosis:
- ☐ Neurogenic Bladder N31.9
- ☐ Stress Incontinence N39.41
- ☐ Hypertrophy (benign) of prostate N40.1
- ☐ Urinary tract infection N39.00
- ☐ Other: _____

Is this diagnosis/condition expected to last more than 90 days? ☐ Yes ☐ No

INTERMITTENT CATHETERS AND SUPPLIES

Intermittent Catheters
- ☐ Straight
- ☐ Coude (select Coude justification below)
  - ☐ BPH
  - ☐ Strictures
  - ☐ False Passage
  - ☐ Inability to pass a straight catheter
- ☐ Hydrophilic
- ☐ Sterile insertion supplies
- ☐ Closed system

Units Per Month
(Medicare allows up to 200 catheters per month)
- ☐ 1 per day/30 month
- ☐ 2 per day/60 month
- ☐ 3 per day/90 month
- ☐ 4 per day/120 month
- ☐ 5 per day/150 month
- ☐ 6 per day/180 month
- ☐ 7 per day/200 month

Other: _____

Size
- ☐ 8 french
- ☐ 10 french
- ☐ 12 french
- ☐ 14 french
- ☐ 16 french
- ☐ 18 french
- ☐ 20 french

Other: _____

Length
Pediatric:
- ☐ 7-10"

Female:
- ☐ 2.75-7"

Male:
- ☐ 13-16"

Lubricant
Sterile Packets
(Medicare allows 1 per catheterization)
- ☐ 1 per catheter

Tubes
(Medicare allows 2 per month)
- ☐ 1 per month
- ☐ 2 per month

Foley Catheter
(Medicare allows 1 per month)
Qty/Month: _____
Insertion tray ☐ Yes ☐ No
Coude tip required ☐ Yes ☐ No
Silicone required ☐ Yes ☐ No

Size
- ☐ 14 ☐ 20
- ☐ 16 ☐ 22
- ☐ 18

Other: _____
- ☐ 5ml ☐ 30ml

Bed Bags
(Medicare allows 2 per month)
- ☐ 2

Leg Bags
(Medicare allows 2 per month)
- ☐ 2

Male External Catheters
(Medicare allows 35 per month)
Size: _____
- ☐ 1 per day/30 per month
- ☐ 35 per month

Notes/Other Supplies/Preferred Brand:

Prescription - Must be completed and signed by the physician, nurse practitioner, or physician assistant who is prescribing the product.

Office contact: _____ Email: _____ Direct line or text: _____

Clinician name (please print): _____ NPI#: _____

Clinician's signature: _____ Date: _____
(original signature required - no stamps) *(must be dated by signator)*

HCD Field Sales Account Representative: _____ Contact Number: _____ Email: _____