Urological Supplies

Physician Order/Prescription

Referred by: Name _____

Office _____

Phone # _____

Fax completed form with Physician's Signature to 704-821-7777

Patient Information

Patient Name: _____ Date of Birth: _____ Gender M / F

Patient Phone #: _____ Alternate Contact: _____ Alternate Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Medicare #: _____ Social Security #: _____

Medicaid #: _____ Secondary Insurance: _____

Urology Supplies Needed

Intermittent Catheters

Select Type:

- ❍ Straight (A4351)
- ❍ Coude (A4352)
- ❍ Closed system (A4353)

Select Size:

- ❍ 5 Fr
- ❍ 6 Fr
- ❍ 8 Fr
- ❍ 10 Fr
- ❍ 12 Fr
- ❍ 14 Fr
- ❍ 16 Fr
- ❍ 18 Fr

Select Length:

- ❍ Pediatric (10" long)
- ❍ Adult (16" long)
- ❍ Female (6" long)

Quantity _____ **per 30 days**

Cathing _____ **times per day**

Male Externals (A4349)

- ❍ Small 23mm
- ❍ Medium 28mm
- ❍ Intermed 31mm
- ❍ Large 35mm
- ❍ X-Large 40mm

Quantity _____ **per 30 days**

Drainage Bags

- ❍ 500 ml Leg Bag with tubing, straps (A4358)
- ❍ 1.000 ml Leg Bag with tubing, straps (A4358)
- ❍ 2.000 ml Bedside Drainage Bags (A4357)

Quantity _____ **per 30 days**

Diagnosis Information

Primary Diagnosis/ICD-9 Code:

- ❍ 788.20 Retention of Urine
- ❍ 788.30 Urinary Incontinence Unspecified
- ❍ Other (specify): _____

Length of Need:

- ❍ _____ months
- ❍ 99- lifetime

Start Date: ____ / ____ / ____ (MM / DD / YY)

Additional Supplies:

- ❍ Incontinence Supplies
- ❍ DME _____
- ❍ Other: _____

Physician Information

Physician's Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

NPI #: _____

Physician's Signature _____ **Date** _____/_____/_____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Mobility & More - 251 N. Trade St. Matthews, NC 28105

Phone/Fax 704-821-7777

www.Mobility-More.com