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

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

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

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

Manufacturer: ☐ **No Preference** ☐ ___________________________

☐ Cure Pocket Coude' with Guide Stripe ☐ Cure Male XL (Extra Long) ☐ Cure Ultra14 Female

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

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

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.**

Additional Supplies/Instructions

Office Address Stamp

Physician's Name:___________________________________ **NPI:**____________________

Physician's Signature:_____________________________________ Date:____/____/_______