MEDI-RENTS & SALES INC.

800-540-7252

Urology Supplies

Physician Order/Prescription

Referred by: Name_____

Office_____

Phone #_____

START DATE____/____/_____

Fax completed form with Physician's Signature and Supporting Documentation to 844-825-3613

Patient Information

Patient Name: Date of Birth: Gender M / F

Patient Phone #: Alternate Contact: Alternate Phone #:

Address: City: State: Zip Code:

Insurance & ID# Group # Social Security #:

Medicaid #: Secondary Insurance:

DISCHARGE DATE____/____/_____ **ORDER DELIVERY DATE**____/____/_____

FUNCTIONAL LIMITATIONS_____FAMILY AND SUPPORT SYSTEM ☐ YES ☐ NO

ABILITY TO USE AND CARE FOR EQUIPMENT ☐ GOOD ☐ NEEDS HELP SUITABLE ENVIRONMENT ☐ YES ☐ NO

Products to Dispense

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

Lubricating Jelly

Quantity _____ per 30 days

Diagnosis Information

Primary Diagnosis/ICD-10 Code

- ❍ R33.9 Retention of Urine
- ❍ R32 Urinary Incontinence Unspecified
- ❍ Other (specify):_____

Length of Need

- ❍ ____Months
- ❍ 99- lifetime

Refills:_____

Medical Justification: _____

Date last seen: ____/____/_____

Prognosis:_____

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

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

NPI#: _____ License #: _____ Exp Date: _____ /_____ /_____

Physician's Signature _____ **Date** _____/ _____/_____

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.