

Referral Number:  
Referral Name, Address and Phone:

## Urology Order Form

▶ Required Information    ☐ Face Sheet Attached

### PATIENT INFORMATION:

▶ Patient Name (Last, First): \_\_\_\_\_ ▶ Date of Birth (MM/DD/YY): \_\_\_\_\_

▶ Street: \_\_\_\_\_

▶ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

▶ Phone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Language: ☐ English ☐ Spanish ☐ Other: \_\_\_\_\_ Email: \_\_\_\_\_

▶ Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Phone: \_\_\_\_\_

### PLAN OF CARE:

▶ Start Date: \_\_\_\_\_ ▶ Length of need: 99=Lifetime unless otherwise indicated. ☐ Other: \_\_\_\_\_ Months

Does patient have UTI history (at least 2 within last 12 months)? ☐ Yes\* ☐ No

Latex Allergy? ☐ Yes ☐ No

▶ ICD10 Diagnosis: ☐ Enuresis not due to a substance or known physiological condition F98.0

☐ Neuromuscular dysfunction of bladder, unspecified N31.9 ☐ Retention of urine, unspecified R33.9

▶ Primary/Causal Diagnosis: \_\_\_\_\_

\*If yes, and the patient's insurance provider follows Medicare guidelines, fax a copy of lab work and supporting documentation along with this form.

### RECOMMENDED SUPPLIES:

Urological Items	Brand Preference	French Size/Length	Frequency of Use	Qty/Mo
Intermittent Catheters <input type="checkbox"/> Straight <input type="checkbox"/> Coudè <input type="checkbox"/> Hydrophilic <input type="checkbox"/> Silicone <input type="checkbox"/> Red Rubber <input type="checkbox"/> PVC				
Closed System Intermittent Catheter <input type="checkbox"/> Straight <input type="checkbox"/> Coudè				
Closed System Intermittent Catheter <small>(includes insert, suppl.)</small> <input type="checkbox"/> Straight <input type="checkbox"/> Coudè				
Male External Catheters				
Leg Bag				
Foley Catheter <input type="checkbox"/> Two-Way <input type="checkbox"/> Three-Way <input type="checkbox"/> Latex <input type="checkbox"/> Silicone				
Foley Insertion Trays <input type="checkbox"/> with bag <input type="checkbox"/> without bag				
Lubricant <input type="checkbox"/> packets <input type="checkbox"/> tube <i>(Medicare covers one packet per catheter.)</i>				
Other				
Incontinence Items	Size/Type	Frequency of Use	Qty/Mo	
Diapers				
Pullups				
Liners				
Other				

NAME, NPI#

NAME, NPI#

NAME, NPI#

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*Licensed Healthcare Provider's Acknowledgement:* My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Byram Healthcare regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

▶ Licensed Healthcare Provider's Signature: \_\_\_\_\_

Signature stamps are NOT acceptable

Date stamps are NOT acceptable

▶ Date: \_\_\_\_\_

**For more information, please call: 1-800-364-6057**

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