SAGE MEDICAL SUPPLY

UROLOGICAL ORDER FORM

Phone: 484.364.3039 • Fax: 610.471.0791

PATIENT INFORMATION

Patient Name: _____ DOB: __/__/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other:

Does the patient have a latex allergy: ☐ YES ☐ NO

Has the patient had two or more Urinary Tract Infections (UTI) in the previous year? *(If yes, please attached supporting labs)*
☐ YES ☐ NO

Primary Diagnosis- ICD-10 Code:

- ❑ R33.9 Retention of Urine, Unspecified
- ❑ R32 Unspecified Urinary Incontinence
- ❑ N35.9 Urethral Structure, Unspecified
- ❑ N31.9 Neuromuscular Dysfunction of bladder, unspecified
- ❑ N40.1 Enlarged Prostate with lower urinary tract symptoms
- ❑ G82.20 Paraplegia, unspecified
- ❑ G35 Multiple Sclerosis
- ❑ Other Diagnosis: _____

Secondary Diagnosis- ICD-10 Code: _____

Length of Need: **____ Months** Start Date: **__/__/____**

Notes:

PRODUCT SELECTION

INTERMITTENT CATHETERS			MALE EXTERNAL CATHETERS	FOLEY CATHETER
Type	*Size*	*Length*	*Size*	*Size*
❑ Straight ☐ Hydrophilic Straight ❑ Coude ☐ Hydrophilic Coude ❑ Closed System ❑ Red Rubber	❑ 6FR ❑ 8FR ❑ 10FR ❑ 12FR ❑ 14FR ❑ 16FR ❑ 18FR	❑ 6” (female) ❑ 10” (pediatric) ❑ 16” (adult)	❑ SMALL ____ mm ❑ MEDIUM ❑ LARGE ❑ X-LARGE	❑ 5cc ❑ 10cc ❑ 30cc French Size: _____ ☐ Latex ☐ Silicone

BRAND: _____ Item#: _____ FREQUENCY: ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 4x/day

ACCESSORIES

Drainage Bags:			*Other:*	
☐ Bedside Bag	☐ 2000ml ☐ 4000ml	QTY: _____	☐ Foley Insertion Tray	Qty: _____
			☐ Foley Irrigation Tray	Qty: _____
			☐ Intermittent Catheter Tray	Qty: _____
☐ Leg Bag	☐ 500ml ☐ 1000ml	QTY: _____	☐ Leg Strap: __medium __large	Qty: _____
			☐ Extension Tubing	Qty: _____
			☐ Lubricant: __ ind. packets __ tube	Qty: _____
			☐ Syringe	Qty: _____

Facility Name: _____	Contact Person: _____	Phone: _____
Address:		Fax: _____
Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email		Email: _____

Ordering Physician (Please Print): _____ NPI#: _____ License #: _____

Physician Signature: _____ Date: __/__/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that maybe disclosed. I certify that my decision to prescribe this recommended product was based solely based on my determination of medical necessity set forth herein.

Assignment of Benefits: *I request that payment of my insurance benefits be made to Sage Medical Supply for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to Sage Medical Supply, which may be needed to determine benefits payable for these services or supplies. I authorize Sage Medical Supply to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: __/__/_____