GNS MEDICAL

Address: 8031 Ortonville Road,
Ste. 150, Clarkston, MI 48348
Office: (810) 208-6006

Catheter Written Order Form

Please fax completed form to: (810) 208-6007

Patient Contact Information

Name: _____ **Date of Birth:** _____ **Phone Number:** _____

Address, City, State, Zip Code: _____

Insurance Provider: _____ **Insurance ID:** _____ **Insurance Phone #:** _____

Diagnosis

☐ R32 – Incontinence, Unspecified ☐ R33.9 – Retention of Urine, Unspecified ☐ R39.14 – Incomplete Bladder Emptying ☐ Other Diagnosis: _____

Dispensing Information

Start Date: _____ **Is this patient currently being seen by:** ☐ Home Health Agency ☐ Hospice

Length of Need & Number of Refills: _____ ☐ 99 (Lifetime) ☐ Other _____ **Does the patient have UTI history?** *(2 UTIs in a 12-month period)* ☐ Yes ☐ No

Item Description for Intermittent Catheter Supplies

French Size:
- ☐ 8 Fr.
- ☐ 10 Fr.
- ☐ 12 Fr.
- ☐ 14 Fr.
- ☐ 16 Fr.
- ☐ 18 Fr.
- ☐ Other: _____

Length:
- ☐ Male
- ☐ Female
- ☐ Pediatric
- ☐ Other: _____

Product & Lubricants:
- ☐ Straight Tip A4351
- ☐ Coude Tip A4352
- ☐ Closed Systems A4353
- ☐ Lubricant Packets A4332

Frequency of Catheters & Lubricant Packets:
- ☐ 2 per day / 60 per month
- ☐ 3 per day / 90 per month
- ☐ 4 per day / 120 per month
- ☐ 5 per day / 150 per month
- ☐ 6 per day / 180 per month
- ☐ 7 per day / 210 per month
- ☐ _____ per day / _____ per month

Description: ☐ Pre-Lubricated ☐ Hydrophilic ☐ Other: _____

Confirmation

Prescriber's Signature: _____ **Printed Name:** _____

Facility Address: _____ **Date:** _____

NPI #: _____ **Revised:** _____

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for the urological supplies listed. I certify, to the best of my knowledge, that the medical necessity information contained in this document is true, accurate, and complete.

~Please Attach & Include Medical Records & Insurance Information~