Hart Medical Equipment

Please fax to: (248) 353-4260

Questions call: (888) 606-8778

Urological Supplies Rx

❑ New Order
Order Date: _____ ❑ Reorder Length of Need: (1-99 months) _____

For office use only
Account #: _____
Document Type: Physician Order

Patient Name: _____ D.O.B.: _____

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

Phone: _____ Ht:_____ Wt:_____ Sex: ❑ M ❑ F Insurance #: _____

Does the patient have a nurse making home visits? ❑ Yes ❑ No *If yes & patient has Medicare, please contact the nursing agency for supplies.*

Nursing Agency: _____ Phone: _____ Contact: _____

Medical Necessity

Note: Answers must be supported by information in the patient's medical record.

Primary Dx: ❑ Urinary Incontinence, R32 ❑ Urinary Retention, R33.9 Secondary Dx: _____ _____ _____

If intermittent catheters are ordered, how many times per day is the patient to self-cath.? _____

If coudé tip is ordered, why can't pt. use straight tip? _____

Does patient have a latex allergy? ❑ Yes ❑ No Is patient confined to a bed? ❑ Yes ❑ No

Does patient have a history of catheter obstruction? ❑ Yes ❑ No Is patient immunosuppressed? ❑ Yes ❑ No

Does patient have a history of urinary tract infections (UTIs)? ❑ Yes ❑ No If yes, how many UTIs in past 12 months? _____

Hart Formulary

Note: Formulary is not manufacturer specific. Substitution for a specific brand name is permitted.

❑ Indwelling / Foley Catheters (QTY 1 per 30 days): Tip: ❑ Straight ❑ Coudé Balloon: ❑ 5 cc ❑ 30 cc French: _____ Length: _____

❑ Intermittent Catheters (QTY _____ per day x 30 = _____ per 30 days): Tip: ❑ Straight ❑ Coudé French: _____ Length: _____

❑ Intermittent Hydrophilic Caths. (QTY _____ per day x 30 = _____ per 30 days): Tip: ❑ Straight ❑ Coudé French: _____ Length: _____

❑ External Catheters (35 per 30 days): ❑ 23mm (Sm.) ❑ 28mm (Med.) ❑ 31mm (Int.) ❑ 35mm (Lg.) ❑ 40mm (XLg.)

❑ Foley Catheter Insertion Tray (QTY 1 per 30 days): Swabs: ❑ BZK ❑ PVI Syringe: ❑ 10 cc ❑ 30 cc

❑ Intermittent Catheter Insertion Tray (QTY _____ per day x 30 = _____ per 30 days): Swabs: ❑ BZK ❑ PVI

❑ Leg Bag (QTY 2 per month): Capacity: ❑ 500cc (19 oz.) ❑ 1000cc (32 oz.)

❑ Overnight Drain Bag (QTY 2 per month)

❑ Foley Catheter Holder with Velcro Leg Band (QTY 1 per month)

❑ Extension Tubing w/Connector (QTY 2 per month)

❑ Sterile Lubricating Jelly 4oz. Bottle (QTY _____ per 30 days)

Additional Supplies Needed

Item(s)	Frequency of use (# per day/week/month)	Quantity Ordered (per month)
_____	_____ per _____	_____
_____	_____ per _____	_____
_____	_____ per _____	_____
_____	_____ per _____	_____

Prescriber Information

Physician Name: _____ NPI #: _____ Phone: _____

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

Physician Signature: _____ Date: _____
(No signature / date stamps)