



Northeast Medical Products, Inc

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www.northeastmedicalproducts.com

CATHETER ORDER FORM
FOR MEDICARE PATIENTS, INCLUDE PROGRESS NOTES

Patient Information:

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone: _____ Alt Phone: _____

Diagnosis:

- Retention of Urine (788.20/R33.9)
- Incomplete Bladder Emptying (788.21/R39.14)
- Other Specified Retention of Urine (788.29/R33.8)
- Urinary Incontinence (788.30/R32)
- Urge Incontinence (788.31/N39.41)
- Other Diagnosis _____

Order Date _____

Length of Need _____ 12 months (One Year)

Does Patient Have Permanent Urinary Incontinence or Retention? Yes No

(Note: Permanency is defined as a condition that is expected to last greater than 90 days)

Please Check Desired Product and Indicate Size & Quantity in Box Provided

Supplies		Size	Quantity to Dispense
Straight Intermittent (A4351)	<input type="checkbox"/>	Fr _____	____ Per month
Coude Intermittent (A4352) *	<input type="checkbox"/>	Fr _____	____ Per month
Closed System (A4353)	<input type="checkbox"/>	Fr _____	____ Per month
External Cath (A4349)	<input type="checkbox"/>	23 - 28- 32-36	____ Per Month
Lubricant Packet (A4332)	<input type="checkbox"/>		____ Per month
Lubricant Tube (A4402)	<input type="checkbox"/>		
Overnight Drain Bag (A4357)	<input type="checkbox"/>		____ Per month
Leg Bag (A4358)	<input type="checkbox"/>		____ Per month

*When a Coude tip catheter is used there must be documentation in the beneficiary's medical record of the medical necessity for that catheter. An example would be the inability to catheterize with a straight tip catheter.

Physician Information:

Physician Name: _____ NPI: _____

Office Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Physician Signature _____ Date: _____

(Attach Physician Notes)