Physician's Order for PureWick™ for Home

Urological Supplies, Inc.

Urological Supplies, Inc.
9841 Bernwood Place Dr. #130
Fort Myers, Florida 33966
Phone: 239.985.9327
Fax: 239.985.9614
PTAN: 6490090001

Patient Name:

Address:

DOB:

Phone:

Rx LENGTH

☐ Initial ☐ Renewal ☐ Revised

RX Period From:_____To:_____
Estimated Length of Need (# of Months) _____
(1-99 (99=Lifetime) Must Be > 3 Months)
Monthly refills required per year _____

PROGNOSIS – Check One

☐ Poor ☐ Fair ☐ Guarded ☐ Good

DIAGNOSIS

☐ N39.3 Urinary incontinence N39.49 ☐ N39.41 Urge incontinence ☐ N39.46 Mixed incontinence ☐ N39.49 Other specified incontinence

ITEMS REQUESTED

☐ (PureWick™) External Urinary Catheters; Disposable, with wicking material, for use with suction pump, per month (A6590)

☐ Canister, Non-Disposable, Used with suction pump, each (A7001)

☐ Tubing, Used with suction pump, each (A7002)

☐ Suction Pump Home Model rental per month (E2001)

FREQUENCY AND QUANTITY

PureWick™: Frequency: _____ per day Quantity: _____ per month
(Maximum 30 catheters allowed per month)

Canister, Non-Disposable with suction pump: Quantity Per every 6 Months: _____
(One canister allowed 1st month and then every 6 Months)

Tubing used with suction pump: Quantity every 3 months:_____
(One tubing allowed 1st month and then every 3 Months)

Prescriber's Name

_____

Prescriber's Signature

_____

NPI

_____

Date

_____

By my signature above, I am stating that the patient is/was being treated by me. All the information contained, or the Physician Work Order Form accurately reflects the patient's condition and the treatment I prescribed. My medical records for this patient substantiate the prescribed use of the products. I will maintain a copy of this signed original Physician Work Order in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

Remember to include Chart Notes and Patient Demographics FAX ORDER TO: (239) 985-9614