



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

Physician's Order for PureWick™ for Home

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: (727) 472.1351