Urology Order Form

Fax: (775) 313-0372
Phone: (775) 313-0364
www.adessotherapeutics.com

Patient Information (Please Include Patient Demographics with the Order)

Patient Name: _____ Patient DOB: _____
Patient Phone: _____ Patient Email: _____

Plan of Care

Diagnosis: ☐ Urinary Retention ☐ Urinary Incontinence ☐ Other: _____
Secondary Diagnosis: _____
Is the condition Permanent (Medicare defines permanence as a condition that is not expected to be medically or surgically corrected in the beneficiary within 3 months): ☐ Yes ☐ No
Does the Patient have a latex Allergy: ☐ Yes ☐ No
Order Start Date: _____ Duration of Need (99 unless indicated otherwise): _____

Supplies

Catheter	Brand	French Size	Length	Product Number	Frequency of Use
Straight Intermittent					
Coudè Intermittent (Is the patient able to pass a straight tip Catheter ☐ Yes ☐ No)					
Straight Closed System Intermittent (additional Information May Be Required)					
Coudè Closed System Intermittent (additional Information May Be Required)					
Male External Catheters					
Foley Catheter ☐ Bag					
Foley Insertion Tray					
Lubricant Packets					
Other					
Other					

Incontinence Supplies

Item	Brand	Size	Frequency of Use
Diaper			
Pullup			
Liner			
Other			

Referral Information

Referral Facility: _____
Referral Phone: _____
Referral Fax: _____
Referring Clinician: _____
Best Method of Communication: _____

Provider Information

Provider Phone (if different than referral): _____
Provider Fax (if different than referral): _____
Provider Name: _____
NPI Number: _____

Signature: _____ Date: _____