IMPACTMEDICAL

Please Send Your Order Via **Fax** to: **(866) 229-0034**

-OR-

Contact a member of our Client Care Team at: **(866)217-0372**

Urological Prescription Form

RX START DATE:	

PATIENT'S NAME:	

REFERRING FACILITY

NAME:	
CITY/STATE	
PHONE:	
FAX:	

CASE MANAGER

INTERMITTENT CATHETER DETAILS SECTION

1. WHAT TYPE OF CATHETER DOES THE PATIENT NEED?

☐ Sterile Intermittent Catheters

☐ Sterile "Closed/Touchless" *(For Closed Systems/IC Kits see additional details on right)*

2. DOES THE PATIENT NEED A STRAIGHT OR COUDE' TIP?

☐ Straight

☐ Coude' *(For a Coude' Catheter see additional details on right)*

3. WHAT FRENCH (FR) SIZE DOES THE PATIENT NEED?

☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14

☐ 16 ☐ 18 ☐ 20 ☐ 22 ☐ 24

4. WHAT LENGTH OF CATHETER DOES THE PATIENT NEED?

☐ 6" *(Typical length for a **female** catheter)* ☐ ____ Other Length

☐ 16" *(Typical length for a **male** catheter)*

5. DOES THE PATIENT WANT A SPECIFIC BRAND?

☐ Bard ☐ Coloplast ☐ Lo Fric ☐ Rusch

☐ Cure ☐ Hollister ☐ Rochester/Magic ☐ Other:_____

6. WHAT IS THE PATIENT'S ESTIMATED DURATION OF NEED?

☐ Lifetime ☐ Other_____ *(See diagnosis of permanence on right)*

7. WHAT FREQUENCY SHOULD THE PATIENT CATHETERIZE?

_____(times per) ☐ Day ☐ Week ☐ Month

8. TOTAL QUANTITY OF CATHETERS REQUESTED EVERY 90 DAYS

_____*(total catheters based on duration of need and frequency of use. Supplier will not exceed LCD Max allowable)*

9. DOES THE PATIENT NEED LUBRICANT FOR EACH EPISODE OF CATHETERIZATION? ☐ YES ☐ NO

10. SPECIAL REQUIREMENTS (THE CATHETER SHOULD ALSO BE…)

☐ Red Rubber ☐ Latex Free ☐ Hydrophilic ☐ Silicone

NOTES

_____

_____

_____

OTHER ITEMS

☐ Indwelling Catheter; Foley Type *(**Fill out sections 2-10 above)*

☐ Male External Catheters-SIZE:____ *(**Fill out sections 5-8 above)*

☐ Bedside Drainage Bag *(**Fill out sections 5-8 above)*

☐ Urinary Drainage Bag *(**Fill out sections 5-8 above)*

DIAGNOSIS OF PERMANENCE

(One diagnosis below **MUST** be checked*)

☐ Permanent Urinary Incontinence

☐ Permanent Urinary Retention

**Urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention/incontinence is defined as retention/ incontinence that is not expected to be medically or surgically corrected in that beneficiary within 3 months. This does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met.*

DIAGNOSIS FOR COUDE' CATHETERS

(One diagnosis below **MUST** be checked*)

☐ Inability to Catheterize with a Straight Tip

☐ Other:_____

**Use of a Coude (curved) tip catheter (A4352) in female beneficiaries is rarely reasonable and necessary. When a Coude tip catheter is used (either male or female beneficiaries), 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*

CLOSED SYSTEMS/IC KITS

(Both boxes below **MUST** be checked)

☐ I have read the requirements below, and

☐ I have have included documents indicating a condition which qualifies for a IC Kit.

*Intermittent catheterization using a sterile intermittent catheter kit (A4353) is covered when the beneficiary requires catheterization **and** the beneficiary meets one of the following criteria (1-5):*

☐ *1. The beneficiary resides in a nursing facility,*

☐ *2. The beneficiary is immunosuppressed,*

☐ *3. The beneficiary has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization,*

☐ *4. The beneficiary is a spinal cord injured female with neurogenic bladder who is pregnant,*

☐ *5. The beneficiary has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant A4332, twice within the 12-month prior to the initiation of sterile intermittent catheter kits.*

Does this patient have a latex allergy? ☐Yes ☐No

Is this patient currently being seen by Home Health Services? ☐Yes ☐No

Has the patient been instructed on how to use the supplies? ☐Yes ☐No

PROVIDERS APPROVAL

(Print Name)

NPI #	
SIGN/DATE	* **DATE:**_____

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Impact Medical Services, L.L.C. for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to Impact Medical Services, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Impact Medical Services, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT SIGNATURE	x