Northeast Medical Products, Inc
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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) _____ Number of refills

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)	☐	Fr _____	_____ Per month
Coude Intermittent (A4352) *	☐	Fr _____	_____ Per month
Foley Catheter Indwelling (A4338)	☐	Fr___ Balloon(cc) 5___30___	_____ Per month
External Cath (A4349)	☐	23 - 28- 32-36 mm	_____ Per month
Lubricant Packet (A4332) Lubricant Tube (A4402)	☐		_____ Per month
Overnight Drain Bag (A4357)	☐		_____ Per month
Leg Bag (A4358)	☐		_____ 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)