MyMedSupplies

When completed, please fax to 866.498.9635

Urological Supplies Prescription

Provider Name:

Phone:

Fax:

NPI:

Patient Name:

Date of Birth:

Date of face to face visit:

Length of Need (in months):

ICD-10 code and written diagnosis:

Catheters

Indwelling catheter with insertion tray /month /daily usage required

Select French size 6 8 10 12 14 16 18 20 22 24

Intermittent catheters with sterile lubricant packet /month /daily usage required

Select French size 6 8 10 12 14 16 18 20 22 24

External catheters /month Size ______mm /daily usage required

Tip style (select one) Straight tip Coude tip

Supplies

Anchoring device 8/month

Extension tubing 2/month

Leg/Abdomen bag 2/month

Bedside drainage bag 2/month

Prescriber Signature ________________________________ Date___________________________

CMN.UROAK.2020