PHYSICIAN ORDERS—CATHETERS

FAX: (800) 638-0294

AMERICA'S Best Care PLUS, INC.
A Pharmacy Partner You Can Depend On

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ SSN: _____

PATIENT PHONE NUMBER: (____) ____ -_____ ALT PHONE NUMBER: (____) ____ -_____

PLAN OF CARE

☐ Retention of Urine (788.20/R33.9) ☐ Urinary Incontinence (788.30/R32)

☐ Incomplete Bladder Emptying (788.21/R39.14) ☐ Urge Incontinence (788.31/N39.41)

☐ Other Specified Retention of Urine (78829/R33.8) ☐ Other Diagnosis _____

Does Patient Have Permanent Urinary Incontinence or Retention? ☐ Yes ☐ No

(Note: Permanency is defined a s a condition that is expected to last greater than 90 days)

Do any of the following conditions apply? ☐ Two UTIs/12 months ☐ Immunosuppressed ☐ BPH ☐ Stricture ☐ Spina Bifida ☐ Paraplegia ☐ Quadriplegia

Number of Refills (Length of Need) ☐ 99 (Lifetime) ☐ 12 (one year) ☐ Other _____

Brand: ☐ hi-slip (Hydrophilic) ☐ Cure Medical ☐ Bard ☐ Coloplast ☐ Other _____

Catheter Supplies			Qty to Dispense	Frequency	Size
☐ Straight Tip Catheter (A4351)	☐ with lubricant	☐ Hydrophilic	per _____ month	_____time(s) per day	_____Fr
☐ Coudé Catheter (A4352)	☐ with lubricant	☐ Hydrophylic	per _____ month	_____time(s) per day	_____Fr
☐ Closed System Catheter Kit (A4353)	☐ Straight ☐ Coudé	☐ Hydrophilic	per _____ month	_____time(s) per day	_____Fr

☐ **90 Day Supply Authorized:** Patient may receive up to a 90 day supply at patient's own choosing. Quantity to dispense will be three times the monthly amount.

I certify that I am the treating physician identified on this form. I have received and completed the sections of this Prescription/Detailed Written Order (DWO). Any statement on my letterhead, attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I certify that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____ _____ _____

Physician Signature ***(No Stamps)*** **NPI #** **Order Date** ***(Required)***

Physician Name: _____ Office Name: _____

Office Address: _____ Phone: _____

City, State, ZIP: _____ Fax: _____