ALL·STAR MEDICAL

Standard Written Order: Urological

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10)

Product	Size	Frequency of Change
☐ Intermittent Straight Tip Catheter (A4351)	☐ 8FR	☐ 2 per day/60 month/180 per 3 months
☐ Coude Tip Catheter (A4352)	☐ 10FR	☐ 3 per day/90 month/270 per 3 months
☐ Closed System/Sterile Catheter (A4353)	☐ 12FR	☐ 4 per day/120 month/360 per 3 months
Specify product number:_____	☐ 14FR	☐ 5 per day/150 month/450 per 3 months
	☐ 16FR	☐ 6 per day/180 month/540 per 3 months
	☐ Other:_____	☐ 7 per day/210 month/630 per 3 months
		☐ Other:_____

Product	Description	Dispensing Quantity	Frequency of Change
Lubricant	☐ Packet/Each (A4332)		
	☐ 4oz Tube (A4402)		
Collection Device	☐ Leg Bag (A4358)		
	☐ Bedside bag (A4357)		
	☐ Bedside bottle (A5102)		
Indwelling Catheters	☐ Foley Two Way Latex (A4338)		
	☐ Foley Two Way Silicone (A4344)		
	☐ Specialty- Coude, Mushroom, Wing (A4340)		
	☐ Insertion tray		
	☐ Leg strap		
Irrigation	☐ Irrigation Tray (A4320)		
	☐ Irrigation Syringe (A4322)		
	☐ Sterile water/saline (A4217) *Provide volume per administration*		

1. **Ordered Date:** _____ 2. **Length of Need:** _____

Leaving blank presumes Lifetime (99 months)

3. **Please attach medical records supporting necessity of the above ordered item(s).**

4. **Additional comments:**

5. _____ _____

Physician/NP/PA/Medical Practitioner Signature Date

: Signer must match Prescriber Information at the top of this form, or be corrected above

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