

ROBERT JACOBSON SURGICAL PHARMACY
359 EAST MAIN STREET
MOUNT KISCO, N Y 10549
Phone: 914-241-4887 Fax: 914-241-7041

UROLOGICAL SUPPLIES- PHYSICIAN ORDER/DOCUMENTAION

PATIENT: _____ DOB: _____

ADDRESS: _____

****PLEASE ATTACH CHART NOTES TO THIS PRESCRIPTION****

___ A4351 - Intermittent Urinary Catheter- Straight French size _____

___ A4352 Intermittent Urinary Catheter- Coude Tip French size _____

___ A 4332 Lubricant , Individual Sterile packets (1 per each catheter used)

___ A4338 Foley Type Indwelling Fench Size: _____

___ A4349 External-Condom Type

OTHER: _____

FREQUENCY OF USE:

___ times per day (Intermittent or External) ___ times per month (Foley)

of UTI's in a 12 month period: _____ Date of UTI _____ Colony Count _____

Date of UTI _____ Colony Count _____

Date of UTI _____ Colony Count _____

PRIMARY DIAGNOSIS UROLOGICAL (check one)

___ R33.9 Urinary Retention NOS _____ R32 Urinary Incontinence NOS

Other SECONDARY Diagnosis: _____

- Is there Permanent Urinary Retention or Incontinence (> 3 months Duration) _____?
- Planned Duration of catheterization: _____
- Patient has needed catheterization since: _____
- Latex Allergy: _____

COUDE TIP: ___yes ___ No. If Yes please explain Medical Necessity: _____

Additional Information for Consideration: _____

(printed Name, Address & Phone or Stamp) _____

Physician Signature: _____

I confirm I am the physician treating this patient and have seen this patient within the last 6 months to evaluate urological condition. All the information contained in this physician order accurately reflects that patient's urological situation, the regimen I have prescribed and is reflected in the patient's medical records. I will maintain a copy of this signed Physician Order in the patient's Medical file.

Fax completed form to: 914-241-1634 Att: _____