HME Specialists LLC

Send Orders Via
Fax (505) 888-6505 or
Secure Email 5058886505@hmespecialists.com

Urological Supply Order

Patient Information

Patient Name_____ **Home Ph** _____ **Other Ph**_____

Delivery Address _____ **DOB** _____/____/_____

City_____**Zip**_____

Diagnosis (es): Urinary Retention **R33.9** ☐ Neurogenic Bladder **N31.9** ☐
Urinary Incontinence **R32** ☐ Other _____ ☐

Orders

History of documented Urinary Tracy Infection(UTI)? ☐Yes ☐No **Length of Need** 99
If **yes**, how many in the last 12 months?_____ **Latex Allergy**? ☐ Yes ☐ No

Catheters:	**French Size**		**Length**
☐ Intermittent Catheters (**A4351**)	☐ 10	☐ 12	☐ Male (16”)
☐ Intermittent Coude Tip (**A4352**)	☐ 14	☐16	☐ Female (6-10”)
☐ Sterile Intermittent Closed System Kit (**A4353**)	☐ 18	☐ Other _____	☐ Pediatric (8 fr)

Frequency of Catheterization:

☐ 200/month (7 per day)	☐ 180/month (6 per day)	☐ 150/month (5 per day)
☐ 120/month (4 per day)	☐ 90/month (3 per day)	☐ 60/month (2 per day)
☐ 30/month (1 per day)	☐ Other_____	

Accessories

Drain Bag(s):	☐ Leg bag _____Qty	☐ Bedside Bag _____Qty
Lubricant:	☐ 3 Gram packets _____Qty	☐ 4oz Tube_____Qty
Insertion Kit	☐ Gloves, iodine, lap sheet _____Qty	

Please include all documentation supporting necessity of above ordered items

Provider

Treating Provider: (please print) _____ **NPI #:** _____

Provider Signature: _____**, MD, DO, PA, NP Date:** _____