H·R Urological Intermittent Catheter Prescription Form

PLEASE ATTACH INSURANCE INFORMATION • EMAIL: SCRIPT@HRPHARMA.COM • FAX: 717-483-2255

INSTRUCTIONS

- **Complete each section**
- **Attach Insurance Information**
- **Provider Sign & Date**

EMAIL FORM

PATIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____ **Gender:** ☐ Male ☐ Female

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____ Insurance:_____

Condition: ☐ Spinal Cord Injury ☐ Spina Bifida ☐ Multiple Sclerosis ☐ Other:_____

DIAGNOSIS

Primary ☐ N31.9 Neurogenic Bladder ☐ R33.9 Urinary Retention ☐ R32 Urge Incontinence ☐ Other:_____

☐ Permanent ☐ Chronic **UTI History** ☐ Yes ☐ No **Secondary** _____

DISPENSING INFORMATION

Duration of Need ☐ 99=Lifetime ☐ 12 Months **Number of Refills** ☐ 99=Lifetime ☐ 12 Months **Latex Allergy** ☐ Yes ☐ No

FREQUENCY (day / month / 90 days)

☐ 2 / 60 / 270 ☐ 3 / 90 / 270 ☐ 4 / 120 / 360 ☐ 5 / 150 / 450 ☐ 6 / 180 / 540

☐ 7 / 210 / 630 ☐ Other: ____ per day / ____ month / ____ per 90 days

FRENCH SIZE

☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14

☐ 16 ☐ 18 ☐ Other:_____

START DATE

____/____/____

PRODUCT

CLOSED SYSTEM A4353*

MTG EZ-Gripper® 16" Adult
☐ Kit ☐ Non-Kit

MTG Advancer® 16" Adult
☐ Kit ☐ Non-Kit
☐ Mini-Pak ☐ Soft

MTG Kiddie-Kath® 10" Pediatric
☐ Kit ☐ Non-Kit

MTG Cath-Lean® 6" Female
☐ Kit ☐ Non-Kit

MTG Jiffy-Cath® 16" Adult
☐ Kit ☐ Non-Kit ☐ Mini-Pak
☐ Soft ☐ Coude

TruCath™ 16" Adult
☐ Kit ☐ Non-Kit

STRAIGHT TIP A4351*

TruCath™ Intermittent
☐ 16" Male ☐ 16" Soft Male
☐ 7.5" Female ☐ 10" Pediatric

TruCath™ Hydrophilic
☐ 16" Male ☐ 16" Soft Male
☐ 7.5" Female ☐ 10" Pediatric

COUDE TIP A4352*

TruCath™ Intermittent Coude
☐ 16" Male ☐ 10" Pediatric

TruCath™ Hydrophilic Coude
☐ 16" Male ☐ 16" Soft Male ☐ 10" Pediatric

mtg TruCath™

☐ **Dispense as Written**

INSERTION KITS

☐ with drainage bag A4310*
☐ without drainage bag A4354*

PREMIUM LEG BAG A4358*

☐ 500ml ☐ 1000ml

DRAINAGE BAGS A4357*

☐ 2000ml

HR® LUBRICATING JELLY

☐ **Packet, each** A4332* *one packet per cath*
Frequency per day _____ *Quantity per month* _____

☐ **Tube, 4oz** A4402*
Quantity per month _____

☐ **Tube, 2oz** A4402*
Quantity per month _____

SUPPLIER**

☐ No Preference ☐ Suggested Supplier:_____ Rep: _____

PROVIDER INFORMATION Signature & date stamps are NOT acceptable

Facility Name:_____ **Facility Phone:**_____

Facility Address:_____ City:_____ State:_____ Zip Code:_____

Prescribing Practitioner Name:_____ **NPI#:**_____

Provider Signature:_____ **Date:**_____

My signature acknowledges that I have read the Terms found on the bottom of this form to the patient and the patient consented. Signature & date stamps are not acceptable.

Order Contact Name:_____ **Email / Phone:**_____

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