Springfield
2240 W. Sunset, Ste. 104
Springfield, MO 65807

Cape Girardeau
286 Christine Street
Cape Girardeau, MO 63703

PHONE: **1-800-637-9201**
FAX: **1-417-269-0692**

HPS UROLOGICAL FORM

Order Date ______________________

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ____ /____ / ____ ☐ Female ☐ Male
Address: ______________________ _____ City: ______________ ___ State: ________ Zip: ________ ______
Phone: (____) ____ - ________ Alternate Phone: (____) ____ - ________ Email: ______________________
Preferred method of contact: ☐ Phone ☐ Email ☐ Text ☐ Other: ______________ Height: ________ in. Weight: _______ lb.

Allergies:

Diagnoses:

Dx / ICD-10 Codes:

Please attach additional pages if necessary, including front and back of insurance card

UROLOGICAL SUPPLIES

Intermittent Catheters:

FR Size ______

☐ Straight
☐ Coude
☐ Hydrophyllic

Quantity _______

Refills _______

Frequency _______ per day

Foley:

Size______ Balloon_______cc

☐ Latex
☐ Silicone

External Size _______

Quantity _______

Refills _______

Frequency _______ per day

Accessories:

☐ Insertion Tray, Quantity _______, Refills ______
☐ Lubricant, Quantity _______, Refills ______
☐ Ext. Tubing, Quantity ______, Refills _______
☐ Leg Bag, Quantity _______, Refills ______
☐ Drain Bag, Quantity ______, Refills _______
☐ Sodium Chloride (500/1,000ml), Quantity _______, Refills _______
☐ Irrigation Syringes, Quantity _______, Refills ______
☐ Other Product Information:
____
______________________________,
Quantity _______, Refills ______

UROLOGICAL SUPPLY LENGTH OF DISPENSE: select below

☐ _____ day supply
☐ 30 day supply
☐ 90 day supply

UROLOGICAL SUPPLY ORDER LENGTH OF NEED: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
Office Phone: (____) ____ - ________ Fax: (____) ____ - ________ Contact: ______________ ___________
Clinic/Hospital Affiliation: ______________________________
Address: ______________________ City: ______________ State: __________ Zip: __________
License #: ______________ NPI #: ______________ Medicaid Provider #: ______________

Physician's Certificate: I certify / recertify that the above listed products / services are Medically Necessary and that this patient is under my care.

Prescriber's signature: ______________________ Date: ____ /____ / ____

Start Date: ____ /____ / ____