PORT CITY MEDICAL | TRUSTED HEALTH PARTNER

ACHC ACCREDITED

PLEASE ATTACH PATIENT DEMOGRAPHIC AND OFFICE NOTES & **FAX TO (251) 650-4498**

NAME_____ **DOB**_____ **GENDER M / F**

ADDRESS_____

PRIMARY INSURANCE_____ **SECONDARY INSURANCE** _____

PHONE_____ **CELL**_____

FRENCH SIZE _____

LENGTH

- ☐ **MALE**
- ☐ **FEMALE**
- ☐ **PEDIATRIC**

INTERMITTENT CATHETER

- ☐ **A4351 – STRAIGHT CATHETER**
- ☐ **A4352 – CATHETER WITH COUDE TIP**
- ☐ **A4353 – TOUCHLESS CATHETER**
- ☐ **A4357 – FOLEY CATHETER** ☐ **COUDE**

DX CODE

- ☐ R33.9 URINARY RETENTION; UNSPECIFIED
- ☐ R32 URGE INCONTINENCE; UNSPECIFIED
- ☐ N31.9 NEUROGENIC BLADDER
- ☐ _____

FREQUENCY OF NEED:

QTY/DAY_____ QTY/MONTH_____

RX START DATE:_____

RX END DATE:_____

ACCESSORIES

- ☐ BED BAG WITH / WITHOUT INSERTION SUPPLIES
- ☐ MALE EXTERNAL CATHETER SIZE: _____ QTY:_____
- ☐ LEG BAG WITH / WITHOUT EXTENSION TUBE
- ☐ LEG / BED BAG DEODORANT CLEANER
- ☐ LUBRICANT

NOTES:

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CLINICIAN'S NAME:_____ NPI:_____

CLINICIAN'S SIGNATURE:_____ DATE:_____

LPN/RN CONTACT NAME:_____ PHONE# _____