ROCKY MOUNTAIN MEDICAL SUPPLY

Medical Supply Rx

Toll Free Fax 1.800.576.1442

Toll Free Phone 1.855.292.9111

Patient Demographics				
Name				
Address				
Date of Birth		**SSN**		**Male / Female**

Diagnosis & Justification

____ 788.30 Urinary Incontinence (R32)

____ 788.20 Urinary Retention (R33)

____ 598.9 Urethral Stricture (N35)

____ Other: _____

____ 596.54 Neurogenic Bladder (N31)

____ 564.81 Neurogenic Bowel (K59.2)

____ Other: _____

____ Other: _____

Length of Need? ..... OTHER_____ or LIFETIME

Does the patient have a history of UTI (2 w/in a 12 month duration) while on CIC regimen..... Y N

Does the patient have ***permanent urinary incontinence***?..... Y N

Does the patient have ***permanent urinary retention***?..... Y N

Note permanent is defined by a condition that is expected to last great than 90 days

Does the patient have radiologically documented vesico-ureteral reflux?..... Y N

Is the patient immunosuppressed?..... Y N

****PLEASE INCLUDE ANY PROGRESS NOTES ****

Rx Effective Date _____

Medical Supply Information

Supply Description	**Size**	**Qty / Day**	**Qty / Month**	Manufacturer Ref # (not required)

Physician Information

Physician Name			
Address			
Office #		**Fax#**	
NPI #		**License #**	

_____ _____

Physician Signature (NO STAMPS PLEASE) **Date**