ROCKY MOUNTAIN MEDICAL SUPPLY

*****PLEASE INCLUDE MOST RECENT PROGRESS NOTES******

Medical Supply Rx

Toll Free Fax 1.800.576.1442

Toll Free Phone 1.855.292.9111

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

Diagnosis & Justification

____ R32 Urinary Incontinence

____ R33.9 Urinary Retention

____ N35.9 Urethral Stricture

____ N31.9 Neurogenic Bladder

____ K59.2 Neurogenic Bowel

____ Other: _____

Length of Need? ..... LIFETIME or OTHER: _____

Number of Refills? 1 2 3 4 5 6 7 8 9 10 11 12

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 greater than 90 days

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

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

******PLEASE INCLUDE MOST RECENT PROGRESS NOTES ****** Order 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) **Signature Date**

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