Finnegan HEALTH SERVICES
6805 W. 12th Street, Suite F
Little Rock, AR 72204
Toll-Free: **1-888-789-6600**
Fax: **501-663-6668**

Urological Prescription Form

Fax to **501-663-6668**. We'll take care of the rest. Form also available at: **finneganhealth.com/forms**

FHSID | **WEB**

1 REFERRER

Referrer Name: _____
Facility/City: _____
Phone #: _____
Email: _____

2 CLINIC

Physician's Name: _____
Clinic/City: _____
Phone #: _____
Diagnoses: _____

3 PATIENT INFORMATION

Name: _____
Date of Birth: _____ **Sex:** M *or* F
Phone #: _____
Email: _____
Address: _____
City/State/Zip: _____
Emergency Contact: _____
Contact #: _____ *Relationship:* _____

Medicaid #: _____
Medicare #: _____
Does patient get home health care *(Medicare only)*? Y *or* N
Insurance Company: _____
Phone #: _____
Policy #: _____ **Group #:** _____

Does patient need automatic shipment? Y *or* N
How often? Monthly Every other month Quarterly

4 CATHETER DETAILS

Catheter Type: ☐ Intermittent ☐ "Closed/Touchless"

Tip Type: ☐ Straight ☐ Coudé

French Size: ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 ☐ 20 ☐ 22 ☐ 24

Length: ☐ 6" *(typical female)* ☐ 16" *(typical male)* ☐ Other: _____

Specific Brand? _____ **Lubricant?** ☐ Yes ☐ No

Estimated Duration of Need: _____

Frequency of Catheterization: _____ *times per* ☐ Day ☐ Month

Special Requirements: ☐ Red Rubber ☐ Latex-Free ☐ Hydrophilic ☐ Silicone

5 OTHER ITEMS

- ☐ Indwelling Catheter *(Foley type)*
- ☐ Male External Catheter *(condom type)*
- ☐ Bedside Drainage Bag
- ☐ Urinary Drainage Bag
- ☐ Diapers *(not covered by Medicare)*
- ☐ Briefs *(not covered by Medicare)*
- ☐ Underpads *(not covered by Medicare)*
- ☐ Other:

M.D., APN, or PA signature + date:

_____