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 **501-686-6668**. We'll take care of the rest. Form also available at: **finneganhealth.com/forms**

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

Discharge Date: ______________________

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" ☐ Foley

Tip Type: ☐ Straight ☐ Coudé Balloon Size ________

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

☐ Male External Catheter *(condom type)*
quantity: ________

☐ Bedside Drainage Bag
quantity: ________

☐ Urinary Drainage Bag
quantity: ________

☐ Other:

M.D., APN, or PA signature:

____

date: ______________________