Finnegan HEALTH SERVICES

1501 N University Ave | Ste 400
Little Rock, AR 72207
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: **ÿnneganhealth.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: _____