Cincinnati Children's™
changing the outcome together

Physician's Order Form

HOME CARE URINARY CATHETERS AND INSERTION SUPPLY

Name: ______________________
DOB: ______________________
MRN: ______________________

REQUIRED: Date of Last **Related** Face to Face Visit with Patient: ______________________
*** If OH Medicaid, required F2F within the last 12 months. If Medicare, requirement is 6 months. Please include a copy of office notes from this F2F with this order.**

Allergies:______________________ Diagnosis:______________________

Order Type: ☐ Initial ☐ Renewal ☐ Change to existing order? ☐ Size Change ☐ Increase Original Start of Care Date: ______________________
Refill?: ☐ Yes - Check here _______ to refill ALL supplies monthly for 1 year OR specify the number ________ of months ☐ No Refills

INTERMITTENT URINARY CATHETERS

Intermittent Catheters: total # per month __________ ☐ Straight Tip
Addtl medical necessity required: ☐ Coude Tip ☐ Olive Tip ☐ Tiemann
Closed System Required? ☐ Yes ☐ **No** **If yes, must complete Medical Necessity Info Box below and additional medical necessity required**

Size: _______ FR _________ Ref# ______________________

Lubricant Packets: total # per month _________ *(1 pk covered per cath)*

Intermittent Frequency:

Daytime: ____ # of times/day Nighttime: ____ # of times/night
****Please confirm this ties to total# ordered***

Kit Cath Tray w/sterile insertion supplies required? ☐ Yes ☐ No
With irrigation syringe*?* ☐ Yes ☐ No
Sterile insertion supplies are separately packaged kits with 1 pair of gloves, antiseptic swab, lubricant, and irrigation syringe (if selected).
If yes, must complete Medical Necessity Info Box below and additional medical necessity required

Letter of Medical Necessity for Sterile Supplies

REQUIRED IF STERILE TECHNIQUE/SUPPLIES/KITS/TRAYS ARE REQUESTED

Sterile technique required? ☐ Yes ☐ No
Does patient have history of urinary tract infections? ☐ Yes ☐ No

Date of Last UTI: _____________

Treatment received: __________________
Has there been a decrease in hospitalization, UTI, or improvement in function as a result of increased catheterization? ☐ Yes ☐ No
Possible outcome if patient isn't catheterized with sterile technique:

____

INDWELLING URINARY CATHETERS

Must also complete medical necessity info box.

Indwelling Catheters total # per month _______ ☐ 2 Way (Foley)
Addtl medical necessity required : ☐ Coude Tip (Foley)

Size: _______ FR _______Balloon/Ref# ______________________

Insertion Trays total # per month ________ *(1 tray covered per cath)*
Trays are separately packaged kits with 1 pair of gloves, antiseptic swab, irrigation syringe, lubricant, tray, and drape

Indwelling Frequency:

Daytime: ____ # of times/day Nighttime: ____ # of times/night
****Please confirm this ties to total# ordered***

Urinary Bag: total # per month ______ ☐ Drain Bag Style ☐ Leg Bag Style

Additional Supplies

Not required separately if ordering insertion supply kits with caths.
May require additional medical necessity.

Gloves: Total # of pairs __________
Is additional size needed for other caregivers? ☐ Yes ☐ No
Are sterile gloves required? ☐ Yes ☐ No
****If yes, must complete medical necessity info box.***

Antiseptic: Total # per month ___________
☐ Benzalkonium Chloride ☐ Alcohol Preps ☐ Alcohol Swab sticks
☐ Betadine® (povidone iodine) ☐ Swabs ☐ Wipes

Irrigation Syringes: ***not for gentamycin***

☐ 35ml – total # ______ ☐ 60ml – total # _________
How often is irrigation required (please explain):

____

Other:

Required:
Ordering Physician Signature/ Credentials: Date (Required):
Printed Name or NPI (Required): Contact Phone #:

Note: This order is for supplies only. Nursing services are not included or implied with this order. If nursing services are needed, please contact the Home Care Referral nurse to set up a visit.
Please fax completed form to Home Medical Equipment 513-636-2470, with a copy of the patient's most recent related F2F notes. Please note, incomplete information may delay your patient's supply order.

Orders faxed by (print name) __________________________ Contact Phone # __________________________

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