STMD Corp
Golden Gate Health Supplies

Fax Back to: (855) 809-8007

CompactCath, Inc.

Have Questions?
Call Us at: (800) 809-8442

ORDER DATE _____

IC PRODUCT & QUANTITY

Size
- ☐ 10 FR
- ☐ 12 FR
- ☐ 14 FR
- ☐ 16 FR
- ☐ 18 FR

Type
- ☐ A4351 Straight
- ☐ A4352 Coude
- ☐ A4353 Intermittent Cath w/ Insertion Supplies

Quantity
- ☐ 30 ☐ 60 ☐ 90
- ☐ 120 ☐ 150 ☐ 180
- ☐ Other: _____

Product (Optional)
- ☐ CompactCath
- ☐ CompactCath Lite
- ☐ OneCath
- ☐ Other _____

PT CATHETERIZING ____ X DAILY / ____ X MONTHLY

OTHER PRODUCTS

	HCPC	Description	Quantity
☐	A4331	EXTENSION DRAINAGE TUBING	_____
☐	A4349	CATHETER; MALE EXTERNAL W/O ADHESIVE, DISP	_____
☐	A4357	BEDSIDE URIN DRAIN BAG, W/WO ANTIREFLX,	_____
☐	A4358	URINARY DRAINAGE BAG, LEG OR ABD	_____
☐	A4360	DISP. EXTERNAL URETHRAL CLAMP OR COMP DEVICE	_____
☐	A5112	URINARY DRN BAG, LEG/ABD, LATEX, W/WO TUBE	_____
☐	_____	_____	_____

LENGTH OF NEED

- ☐ # Monthly Refills ____
- ☐ Lifetime

PATIENT DEMOGRAPHICS

Name _____ Date of Birth _____

Adress _____ Phone _____

DIAGNOSIS

- ☐ (R32) Urinary Incontinence
- ☐ (R39.41) Urge Incontinence
- ☐ (R33.9) Retention of Urine
- ☐ (R33.8) Unspec. Retention of Urine
- ☐ (R39.14) Incomplete Bladder Emptying
- ☐ (N39.3) Stress Incontinence
- ☐ (N40.1) BPH
- ☐ Other: _____

CERTIFICATION OF RX AND MEDICAL RECORDS

PATIENT NOTES:

☐ CHART NOTES AND DEMOGRAPHICS ATTACHED

PRESCRIBER INFORMATION

DR: _____
NPI#: _____
ADDRESS: _____
PHONE: _____
FAX: _____

SIGNATURE

PLEASE NO STAMPS
SIGNATURE

_____
DATE

BY SIGNING ABOVE: I AUTHORIZE THE USE OF THIS DOCUMENT AS A LEGAL PRESCRIPTION. I CERTIFY THE UROLOGICAL CATHETERS ARE MEDICALLY NECESSARY AND REASONABLE AND NOT BEING PRESCRIBED FOR CONVENIENCE. I WILL RETAIN A COPY OF THIS DOCUMENT IN THE PATIENTS MEDICAL RECORDS AND WILL PROVIDE IT AT REQUEST FROM MEDICARE, THEIR AUTHORIZED AGENTS, OR ANY OTHER INSURER. I CERTIFY THAT I AM THE CLINICIAN OF RECORD TREATING THIS PATIENT AND ATTEST THE ABOVE IS TRUE AND CORRECT.

COMPACTCATH DISCLOSURE AND PATIENT HIPAA RELEASE: THIS PRESCRIPTION IS AUTHORIZED FOR AND REQUESTED ON BEHALF OF PATIENT _____ DATE OF BIRTH _____ ON A FULLY DOCUMENTED PHONE CALL AND IN WRITING. COMPACTCATH INC., IS OPERATING AS AN AGENT ON THIS PATIENTS BEHALF IN OBTAINING THIS MEDICAL PRODUCT. THIS PRESCRIPTION WILL BE FURNISHED AT THEIR REQUEST TO THE PHARMACY AND/OR DME PROVIDER AND RETAILER OR PATIENTS CHOICE.