



CLOCK MEDICAL SUPPLY, INC.  
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD  
PHONE: 1-620-221-0550

PO BOX 620  
TOLL FREE: 1-800-362-1314

WINFIELD, KS 67156-0620  
FAX: 1-620-221-7460

# FAX

To:

From:

Fax:

Pages: (including cover page)

Phone:

Date:

RE:

Patient DOB:

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## UROLOGICAL ORDER

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To Whom It May Concern:

Please review the following order and complete the information where the ➡ indicates.

Also verify that all the information is correct or make corrections accordingly.

THANK YOU

**Please complete the following:**

**Is the patient currently on Home Health**

**Doctor's Notes**

**Medical Justification for a Specialty Catheter**

**Is patient allergic to Latex/Medical Justification for a Specialty Catheter**

**Physician's Signature and the Date**

**And FAX to 620-221-7460**

**Thank you for your time and help**

**HAVE A GREAT DAY!**

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# UROLOGICAL ORDER



901 Industrial Blvd, PO Box 620  
Winfield, KS 67156  
Phone: 620-221-0550  
Toll Free: 800-362-1314  
Fax: 620-221-7460

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Start Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Update of Order: \_\_\_\_\_

**30 days dispensed for 12 months**

➡ Is this patient currently on Home Health? ☐ Yes ☐ No

If yes, Home Health Name: \_\_\_\_\_

Does the patient have permanent: ☐ Incontinence ☐ Retention ☐ Supra pubic Catheter

## Items to be dispensed per month:

☐ Foley Size: \_\_\_\_\_ Fr \_\_\_\_\_ Bulb ☐ Urethral Size \_\_\_\_\_ ☐ Sheath Size: \_\_\_\_\_  
Catheter \_\_\_\_\_ Change per day \_\_\_\_\_ Sheaths: \_\_\_\_\_

➡ Frequency of change: \_\_\_\_\_  
("as needed" and "prn" are not acceptable)

➡ Does patient have a latex allergy? ☐ Yes ☐ No

➡ Medical Justification for Specialty Catheter \_\_\_\_\_  
(i.e. all silicone, coude, lubricated)

## Accessories for Urological:

\_\_\_\_\_ Insert Tray \_\_\_\_\_ Drainage Bag \_\_\_\_\_ Leg Bag \_\_\_\_\_ Ext. Tubing  
\_\_\_\_\_ Leg Strap \_\_\_\_\_ Anchor Device \_\_\_\_\_ Tape \_\_\_\_\_ 4x4 Gauze  
\_\_\_\_\_ Lubricant

## Irrigation Supplies (KS Medicaid ONLY):

\_\_\_\_\_ Sterile Saline \_\_\_\_\_ Syringes

➡ Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Physician's Name: \_\_\_\_\_ Fax #: \_\_\_\_\_