CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD PO BOX 620 WINFIELD, KS 67156-0620
PHONE: 1-620-221-0550 TOLL FREE: 1-800-362-1314 FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: 2 **(including cover page)**

Phone:

Date: 09/23/2015

RE:

Patient DOB:

UROLOGICAL ORDER

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 acccordingly.

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!

UROLOGICAL ORDER

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www.ClockMedical.com
Solving Problems / Delivering Solutions

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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 | 2 each Drainage Bag | 2 each Leg Bag | 1 each Ext. Tubing

1 each Leg Strap | 12 each Anchor Device | 1 roll Tape | 1 pkg 4x4 Gauze

1 tube Lubricant

Irrigation Supplies (KS Medicaid ONLY):

15 bottles Sterile Saline | 15 each Syringes

Physician Signature: _____ Date: _____

Physician's Name: _____ Fax #: _____