680 8th Street, Suite 240H
San Francisco CA 94103
Tel: 1-888-933-2284
www.compactcath.com

From: CompactCath
Fax #: 855-662-2661

To: ______________________

Fax #: ______________________

ATTN: ______________________

RE: ______________________
DOB: ______________________

Hi

Please find the attached Catheter Prescription for patient   who recently contacted us to initiate a catheter order on their behalf. Once received it will be forwarded to the In-Network DME Company for fulfillment.

If you could please:

1. **Review, sign, and date the attached catheter order**
2. **Fax signed copy to: 855-662-2661**
3. **Place original order in the patient's chart**

Should you have any questions, please contact us directly at **1-888-933-2284** (toll free)

Thank you for your assistance and for allowing CompactCath to be part of your patient's care.

IMPORTANT: *This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (1-888-933-2284) to arrange the return or destruction of the information and all copies.*

CATHETER ORDERS

COMPACTCATH

Fax this form to **855-662-2661**

PATIENT DEMOGRAPHICS

NAME: ______________________________ **DATE OF BIRTH:** ______________________

ADDRESS: ______________________________ **PHONE:** ______________________

DIAGNOSIS

PRIMARY ICD-10: R32 **SECONDARY ICD-10:** ____________ **ORDER DATE:** ____________

LENGTH OF NEED: PERMANENT URINARY RETENTION (GREATER THAN 90 DAYS) **OTHER:** ____________

DISPENSE

DISPENSE: COMPACT CATH INTERMITTENT CATHETER **FRENCH SIZE:** ____________ **TIP:** ____________

PLAN OF CARE: ______________________________ **TOTAL MAXIMUM QTY DISPENSED MONTHLY:** ____________

CERTIFICATION OF RX AND MEDICAL RECORDS

PATIENT NOTES:

PRESCRIBER INFORMATION

DR: ______________________________

NPI#: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________

FAX: ______________________________

SIGNATURE

PLEASE NO STAMPS

SIGNATURE: ______________________________

DATE: ______________________________

BY SIGNING ABOVE: *I AUTHORITIZE 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. THAT I AM THE CLINICAN 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. COMPACT CATH INC IS OPERTAING 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 OF PATIENTS CHOICE.