OCHOA'S PHARMACY
Prescriptions, Medical Equipment & Supplies

Urological Patient Referral Form

Phone: (956) 381-0967

STEP 1 Complete this referral form

STEP 2 Attach patient's demographic sheet and any supporting medical record documentation

STEP 3 Fax form to (956) 381-9844

Patient Name _____ **D.O.B.** ___/___/___ ☐ Male ☐ Female **Phone** _____

DIAGNOSIS (check diagnosis)

Start Date ___/___/___

1st Diagnosis

- ☐ R32 Urinary Incontinence
- ☐ R32 Urinary Retention

2nd Diagnosis

- ☐ N440.1 BPH
- ☐ G35 Multiple Sclerosis
- ☐ N31.9 Neurogenic Bladder
- ☐ C61 Prostate Cancer
- ☐ C67.9 Bladder Cancer
- ☐ G82.50 Quadriplegia
- ☐ G82.20 Paraplegia

Spina Bifida (Q05)

- ☐ Q05.4 Unspecific Region...
- ☐ Q05.0 Cervical Region...
- ☐ Q05.1 Dorsal (Thoratic) Region...
- ☐ Q05.2 Lumber Region w/ Hydro...
- ☐ Q05.8 Without Mention...
- ☐ Q76.0 Spina Bifida Occulta
- ☐ Other _____

Duration of Need = lifetime - unless otherwise noted _____

CATHETERS

☐ **Intermittent Urinary Catheter**

☐ Kit with Insertion Supplies ☐ Lubricant Packets ☐ Hydrophilic

☐ **Coudé Intermittent Urinary Catheter**

☐ Kit with Insertion Supplies ☐ Lubricant Packets

Mark Appropriate Justification

☐ BPH w/Obstruction ☐ Strictures ☐ False Passages ☐ Scar Tissue

☐ **Closed System Catheter**

☐ **Male External Catheter**

☐ **Indwelling Foley Catheter** Indicate Type _____

PRODUCT DESCRIPTION

Brand _____

French Size _____

Quantity _____

Freq Change _____ PER MONTH

Length _____

Manufacturer _____ CATHETER

Supplies may be provided by Ochoa's Pharmacy. For additional information call us at (956) 381-0967. This is a confidential message. It is intended solely for the person to whom it is addressed. It must be kept in strict confidence. If you receive this message in error, please forward it by fax to (956) 381-0967 and destroy the copy you received. Thank you.

PATIENT AUTHORIZATION

I request that payment of my insurance benefits (Medicare, Medicare Supplemental or other) be made to Ochoa's Pharmacy for any supplies or services furnished to me by Ochoa's Pharmacy. I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize the release of my medical information/records to my insurer(s) as well as medical professionals. I authorize Ochoa's Pharmacy to contact me by telephone, email or mail regarding my medical supplies.

Patient's Signature _____ **Date** ___/___/___

Use This Area For Comments

_____

_____

_____

_____

_____

_____

REFERRING PHYSICIAN INFORMATION

Office _____

Address _____

Phone _____

Fax _____

Physician's NPI# _____

Physician's Signature _____ **Date** ___/___/___

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of this patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.