LINK Program and Medical Prescription

BARD | CARE

Please attach Patient Demographic Sheet, Insurance Card, Chart Notes and FAX to Bard Care at 888-205-1558

PATIENT INFORMATION

1

NAME (required) _____ Gender ☐M ☐F DOB _____

Address _____ Spanish Speaking Only ☐

City, State, Zip _____ **PHONE** (required) _____

Primary Insurance _____ Secondary Insurance _____

2

Start Date: (required) _____

3

Length of Need: (required)

☐ Lifetime or ☐ Months _____

4

Primary ICD-10 Diagnosis: (required)

☐ R33.9 Urinary Retention; unspecified
☐ R32 Urge Incontinence; unspecified
Other _____

***Secondary ICD-10 Diagnosis:**

☐ N35.919 Urethral Stricture *(coudé tip)*
☐ N32.0 Bladder Neck Obstruction *(coudé tip)*
☐ N40.1 Enlarged prostate with lower urinary tract symptoms *(coudé tip)*
Other _____

***For Coudé catheters, please select a primary and secondary ICD-10 diagnosis**

INTERMITTENT CATHETERS

PRESCRIBED PRODUCTS

5

FR Size _____ (required)

TIP (required)

☐ Straight Tip
☐ Coudé Tip*

LENGTH

☐ Male
☐ Female
☐ Pediatric

6

FREQUENCY OF USE: (required)

☐ 1/day (90/90 days)
☐ 2/day (180/90 days)
☐ 3/day (270/90 days)
☐ 4/day (360/90 days)
☐ 5/day (450/90 days)
☐ 6/day (540/90 days)
☐ Other _____ per day _____ per 90 days

ACCESSORIES

☐ Insertion Supplies
☐ Lubricant Tube (4 oz./month)
☐ Lubricant Packets

7

HYDROPHILIC

☐ Magic³® Hydrophilic w/SureGrip™
☐ Magic³ Go® Hydrophilic
☐ Magic³® Antibacterial Hydrophilic w/SureGrip™

NON-HYDROPHILIC

☐ Magic³® All-Silicone w/Lubricant
☐ Magic³® Antibacterial w/Lubricant
☐ CleanCath® Intermittent Catheter w/Lubricant
☐ Red Rubber Intermittent Catheter w/Lubricant

KITS

☐ Magic³ Touchless™ Catheter
☐ Touchless® Plus System
☐ Bardia® Urethral Catheter and Tray

OTHER PRODUCTS OR SPECIAL INSTRUCTIONS

_____
Please Print Here

***For Coudé tip or intermittent catheter kits, please attach medical documentation to substantiate necessity.**

CLINICIAN INFORMATION

8

My signature below denotes that to the best of my knowledge the patient/caregiver is capable of using the ordered items which are designed for home use and is informed that he/she will be contacted by telephone from Bard Medical and/or a medical equipment supplier regarding covered items ordered. The patient/caregiver has successfully completed training or is scheduled to begin training on the use of the supplies. I have informed the patient/caregiver of Bard Medical's privacy policy.

CLINICIAN'S NAME (required) _____ License # _____ NPI_____

CLINICIAN'S SIGNATURE (required) _____ Credentials _____ **DATE** (required) _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

RN/MA Contact Name _____

☐ **Dispense as written. If not checked, Bard substitutions permitted.**

Summary of Indications, Warnings, Precautions and Contraindications for Intermittent Catheters: Intermittent catheters are intended to be used to drain urine from the bladder. Catheters may contain natural rubber latex which may cause allergic reaction. The most common risk is urinary tract infection. Please consult product labels and inserts for more product information. All rights reserved. International Classification of Diseases, 10th Edition, World Health Organization, Geneva, Switzerland, 2015

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Other _____

For Coudé catheters, please select a primary and secondary ICD-10 diagnosis

PRESCRIBED PRODUCTS

5 MALE EXTERNAL CATHETERS

FREQUENCY OF USE: (required)

☐ 35/mth (105/90 days) ☐ Other _____ per day _____ per 90 days

TYPE OF CATHETER

☐ Spirit® MEC Style 1
☐ Spirit® MEC Style 2
☐ Spirit® MEC Style 3
☐ The Natural® MEC

ACCESSORIES

Leg Bag Kit (☐19 oz) (☐32 oz) *2/mth (6/90 days) Other_____*
Straps (☐Cloth) (☐Latex)
☐ Extension Tubing *2/mth (6/90 days) Other_____*
☐ Drain Bag (2000 mL) *2/mth (6/90 days) Other_____*

6 FOLEY CATHETERS

FREQUENCY OF USE: (required)

☐ 1/mth (3/90 days) ☐ Other _____ per month _____ per 90 days

SIZE AND TIP

FR Size _____ (required)
☐ Straight Tip
☐ Coudé Tip*
(required)

BALLOON SIZE

☐ 1.5cc
☐ 3cc
☐ 5cc
☐ 30cc

TYPE OF CATHETER

☐ Bard® Latex Foley Catheter
☐ Bard® Silicone Foley Catheter

ACCESSORIES

Leg Bag Kit (☐19 oz) (☐32 oz) *2/mth (6/90 days) Other_____*
Straps (☐Cloth) (☐Latex)
☐ Extension Tubing *2/mth (6/90 days) Other_____*
☐ Drain Bag (2000 mL) *2/mth (6/90 days) Other_____*
☐ Foley Insertion Kit *2/mth (6/90 days) Other_____*

OTHER PRODUCTS OR SPECIAL INSTRUCTIONS

FREQUENCY OF USE: (required)

Qty/Day: _____ Qty/90 Days: _____

_____
Please Print Here

For Coudé tip or silicone Foley catheter, please attach medical documentation to substantiate necessity.

CLINICIAN INFORMATION

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