



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) \_\_\_\_\_

4 Primary ICD-10 Diagnosis: (required)
 R33.9 Urinary Retention; unspecified
 R32 Urge Incontinence; unspecified
Other \_\_\_\_\_

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

3 Length of Need: (required)
 Lifetime or  Months \_\_\_\_\_

\*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 \_\_\_\_\_

INTERMITTENT CATHETERS

5 PRESCRIBED PRODUCTS
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
 MAGIC<sup>3</sup> Hydrophilic w/SUREGRIP™
 MAGIC<sup>3</sup> Go<sup>®</sup> Hydrophilic
 MAGIC<sup>3</sup> Antibacterial Hydrophilic w/SUREGRIP™
NON-HYDROPHILIC
 MAGIC<sup>3</sup> All-Silicone w/Lubricant
 MAGIC<sup>3</sup> Antibacterial w/Lubricant
 CLEANCATH<sup>®</sup> Intermittent Catheter w/Lubricant
 Red Rubber Intermittent Catheter w/Lubricant
KITS
 MAGIC<sup>3</sup> Touchless™ Catheter
 TOUCHLESS<sup>®</sup> Plus System
 BARDIA<sup>®</sup> 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 \_\_\_\_\_

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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Dispense as written. If not checked, BARD substitutions permitted.

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PATIENT INFORMATION

1 NAME (required) Gender M F DOB Address City, State, Zip PHONE (required) Primary Insurance Secondary Insurance

2 Start Date: (required)

4 Primary ICD-10 Diagnosis: (required) \*For Coudé catheters, please select a primary and secondary ICD-10 diagnosis Secondary ICD-10 Diagnosis

3 Length of Need: (required) Lifetime or Months

5 MALE EXTERNAL CATHETERS FREQUENCY OF USE: (required) TYPE OF CATHETER ACCESSORIES

6 FOLEY CATHETERS FREQUENCY OF USE: (required) SIZE AND TIP BALLOON SIZE TYPE OF CATHETER ACCESSORIES

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.

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CLINICIAN'S NAME (required) License # NPI

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

Address City, State, Zip Phone Fax RN/MA Contact Name

Summary of Indications, Warnings, Precautions and Contraindications for Intermittent Catheters: Intermittent catheters are intended to be used to drain urine from the bladder.

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