

CARE Program and Medical Prescription BARD CARE



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

		PATIE	NT INFORMATIO	N_			
1 NAME (required)					505		
	Address					_ Spanish Speaking Only 🗌	
	City, State, Zip		PHONE (required) Secondary Insurance				
	Primary Insurance						
2		4 Primary ICI	D-10 Diagnosis: (re	quired)	*50"		
~.	and Balan	□R33.9	Urinary Retention;	unspecified		Coudé catheters, ease select a	
St	cart Date: (required)	R32 Other	Urge Incontinence	unspecified	-	ry and secondary	
3		*Secondary	y ICD-10 Diagnosis:		-	D-10 diagnosis	
	anath of Noods	-	Urethral Stricture (le alagilet.	
	ength of Need: (required)	□ N40.1	N32.0 Bladder Neck Obstruction (coudé tip)N40.1 Enlarged prostate with lower urinary tract symptoms (coudé tip)				
	Lifetime or Months	_ Other					
			TENT CATH	_			
	5	FREQUENCY OF US	E: (required)	7 HYDROF	PHILIC		
		☐ 1/day (90/90 days)	-	☐ Magic ^{3®} Hyc	drophilic w/Sur	REGRIP™	
S	FR Size	2/day (180/90 days)		☐ Magic³ Go°	•		
	(roduirou)	☐ 3/day (270/90 days)		☐ Magic³* Ant Hydrophilia	ibacterial c w/SureGrip™		
<u>ح</u>	TID /	4/day (360/90 days)					
Ö	TIP (required) ☐ Straight Tip	☐ 5/day (450/90 days)			DROPHILIC		
\mathbb{Q}	☐ Coudé Tip*	☐ 6/day (540/90 days)			Silicone w/Lub ibacterial w/Lu		
7		☐ Other per day	per 90 days			atheter w/Lubricant	
	LENGTH	ACCESSORIES				Catheter w/Lubricant	
Ш	LENG I H ☐ Male	☐ Insertion Supplies					
#	☐ Male	☐ Lubricant Tube		KITS □ Magic ³ Tou	chless™ Cathet	·er	
2	☐ Pediatric	(4 oz./month)		☐ Touchless®			
S		☐ Lubricant Packets			thral Catheter	and Tray	
OTHER PRODUCTS OR SPECIAL INSTRUCTIONS							
J							
	Please Print Here					_	
	*Far Cardá tin av intovnij	ttort ootbatay kita mlaa		lisal decuments	** *- oub	-ttit magazitu	
	*For Coudé tip or intermit	Tent catheter kits, pieds	se attach med	alcai documenta	tion to subs	Stantiate necessity.	
		CLINICI	AN INFORMATIO	DN			
8	My signature below denotes that to the be he/she will be contacted by telephone fror training or is scheduled to begin training o	m Bard Medical and/or a medical equipr	ment supplier regardin	g covered items ordered. T	he patient/caregive		
CLINICIAN'S NAME (required)			Licens	e #	NPI	<u> </u>	
CLI	INICIAN'S SIGNATURE (requi	ired)		Credentials	DATE (requ	uired)	
	ress						
	, State, Zip		Summary o	Summary of Indications, Warnings, Precautions and Contraindications for Intermittent Catheters: Intermittent catheters are intended to be used to drain urine from the bladder.			
			Catheters r	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			
Phone Fax			product inf	product information. All rights reserved. International Classification of Diseases, 10th Edition, World Health Organization, Geneva, Switzerland, 2015			
RN/MA Contact Name			Bard, CleanCath, Lubricath, Lubri-Sil, Magic ³ , Natural, Spirit and Touchless are trademarks and/or				
			registered tr	ademarks of C. R. Bard, Inc. ©2 MD/BMDA/0815/0001(3)			
□ D	ispense as written. If not checked	d, Bard substitutions permitte		.5, 2. 15, 4 00.0, 000.(0)			

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COLINK Program and Medical Prescription



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PATIENT INFORMATION							
NAME (required)	Gender □M □F DOB						
Address							
City, State, Zip	DUONE						
Primary Insurance Se	condary Insurance						
Primary ICD-10 Diagnosis: (required)							
	*For Coudé catheters, ontinence; unspecified *Procudé catheters, please select a						
Other							
*Secondary ICD-							
Length of Need: (required)	der Neck Obstruction (coudé tip)						
☐ Lifetime or ☐ Months Other	arged prostate with lower urinary tract symptoms (coudé tip)						
5 MALE EXTERNAL CATHETERS	6 FOLEY CATHETERS						
FREQUENCY OF USE: (required)	FREQUENCY OF USE: (required)						
35/mth (105/90 days) Other per day per 90 days	1/mth (3/90 days) Other per month per 90 days						
TYPE OF CATHETER	SIZE AND TIP BALLOON SIZE TYPE OF CATHETER						
☐ Spirit® MEC Style 1	FR Size						
☐ SPIRIT® MEC Style 2	(required) 3CC						
SPIRIT* MEC Style 3	Foley Catheter						
☐ The Natural® MEC	☐ Coudé Tip*☐ 30cc (required)						
	ACCESSORIES						
ACCESSORIES	Leg Bag Kit (☐19 oz) (☐32 oz)						
Leg Bag Kit (_19 oz) (_32 oz) 2/mth (6/90 days) Other	Straps (Geletif) (Gratex)						
Straps (Cloth) (Latex) Extension Tubing 2/mth (6/90 days) Other	☐ Extension Tubing 2/mth (6/90 days) Other						
☐ Extension Tubing 2/mth (6/90 days) Other ☐ Drain Bag (2000 mL) 2/mth (6/90 days) Other	☐ Drain Bag (2000 mL)						
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 at	*For Coudé tip or silicone Foley catheter, please attach medical documentation to substantiate necessity.						
CLINICIAN I	INFORMATION						
he/she will be contacted by telephone from Bard Medical and/or a medical equipment s	capable of using the ordered items which are designed for home use and is informed that 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	e 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	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						
RN/MA Contact Name	product information. All rights reserved. International Classification of Diseases, 10th Edition, World Health Organization, Geneva, Switzerland, 2015						
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