PLEASE FILL OUT THE ENTIRE FORM AND INCLUDE THE PATIENT'S DEMOGRAPHIC TO **AVOID DELAYS** .

PRISM
HOME MEDICAL SUPPLY SPECIALISTS
PHONE: (888) 244-6421
FAX: (800) 975-6321
WWW.PRISM-MEDICAL.COM

(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT NAME: _____ ***ORDER START DATE:*** ___/____/_____
PATIENT PHONE: _____ PATIENT DOB: _____/_____/_____
REFERRAL FACILITY: _____ CITY:_____ STATE:____
REFERRAL PHONE: _____ FAX: _____

1. DIAGNOSIS OF PERMANENCE *(ONE MUST BE SELECTED)*: **URINARY INCONTINENCE** ☐ **URINARY RETENTION** ☐ **ICD 10:**_____
2. EXPECTED DURATION OF NEED *(ONE MUST BE SELECTED)*: **LIFETIME** ☐ **OTHER** ☐ **PLEASE EXPLAIN:** _____
3. IS PATIENT RECEIVING HOME HEALTH SERVICES? **YES** ☐ **NO** ☐ **4.** LATEX ALLERGY? **YES** ☐ **NO** ☐
5. HAS THE PATIENT BEEN ASSESSED WITHIN THE PAST 6 MONTHS? **YES** ☐ **NO** ☐ **IF YES, PLEASE PROVIDE DATE**: _____/_____/_____

ITEMS DESIGNATED BY AN ASTERISK (*) MUST MEET ADDITIONAL CRITERIA AND DOCUMENTATION REQUIREMENTS

(SECTION 2A) CATHETER TYPES

INTERMITTENT	INDWELLING	EXTERNAL
INTERMITTENT ☐	FOLEY ☐	MALE EXTERNAL (CONDOM CATHETER) ☐
*STERILE INTERMITTENT KIT(CLOSED SYSTEM) ☐	_____	_____

(SECTION 2B) CATHETER DETAILS MUST HAVE QUANTITY PER MONTH

TIP TYPE: STRAIGHT ☐ * COUDE ☐ **(IF COUDE IS SELECTED, PLEASE COMPLETE REQUIRED FIELD BELOW)**

INABILITY TO CATHETERIZE WITH STRAIGHT TIP: ☐ IF OTHER, PLEASE EXPLAIN: _____

FRENCH SIZE: **6** ☐ **8** ☐ **10** ☐ **12** ☐ **14** ☐ **16** ☐ **18** ☐ **20** ☐ **22** ☐ **24** ☐ LENGTH: _____ **in.** Supplier will default to 6" for females 16" for males

INDWELLING BALLOON SIZE: _____ MALE EXTERNAL SIZE: _____ SPECIAL REQUIREMENTS: _____

BASED ON FREQUENCY, TOTAL QUANTITY OF CATHETERS REQUESTED PER MONTH **(SUPPLIER WILL NOT EXCEED CMS MAX ALLOWED):** _____

(SECTION 3) ADDITIONAL ITEMS MUST HAVE QUANTITY PER MONTH FOR EACH

ADDITIONAL ITEMS	CHECK	TOTAL QUANTITY PER MONTH
BEDSIDE DRAINAGE BAG	☐	
URINARY DRAINAGE BAG	☐	
INSERTION KIT **(FOR USE WITH INDWELLING CATHETER ONLY)**	☐	
IRRIGATION TRAY	☐	
LUBRICANT	☐	
OTHER: _____	☐	

(SECTION 4) SUPPLY ASSESSMENT

DOES THE PATIENT CURRENTLY HAVE ANY OF THE REQUESTED PRODUCT/S AT HOME? ☐ **YES** ☐ **NO**

*IF **YES**, LIST THE QUANTITY REMAINING OF **EACH** PRODUCT THE PATIENT CURRENTLY HAS IN THE NOTES SECTION*

(SECTION 5) NOTES

(SECTION 6) AUTHORIZATIONS

IS THE PATIENT REQUESTING COORDINATION OF CARE? ☐ **YES** ☐ **NO**
(THE PATIENT HAS CHOSEN PRISM TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FORSERVICE(S) OR COORDINATING CARE SHOULD DIRECT SERVICE NOT BE AN OPTION.)

(SECTION 7) PROVIDER SIGNATURE

PROVIDER'S NAME: _____
PROVIDER'S NPI: _____
SIGNATURE: _____
DATE: _____/_____/_____

****(If the PROVIDER listed herein is best reached at a location other than the referring facility detailed in Section 1, please provide the PROVIDER'S contact information below.)***
PROVIDER PHONE: _____
PROVIDER FAX: _____

PRISM
HOME MEDICAL SUPPLY SPECIALISTS

Patient Demographics Form

Form must be filled out entirely to complete the patient file.

Patient Name: (First) (Middle Initial) (Last Name)

Please enter name as it appears on the insurance card.

Date of Birth: **Social Security Number**:

Address:

City: **State**: **Zip**:

Best Contact Number:

Shipping Address:

Same as Billing

Alternate Ship To Address:

City: **State:** **Zip:**

Primary Insurance:

Carrier Name:

Policy Number: **Group Number:**

Phone Number:

Secondary Insurance:

Carrier Name:

Policy Number: **Group Number:**

Phone Number:

Notes:

SUBMIT

Info Taken By: