Phone: (801) 728-3333
Fax to: (801) 728-3340

PETERSEN MEDICAL

Standard Written Order

Patient name: ______________________ DOB: ______________

Diagnosis

__________ __________ __________ __________ __________

Start date: ______________ Estimated length of need (# in months): ______ 1-99 (99=lifetime)

Catheter:

☐ Straight Tip A4351 ☐ Coudé A4352 ☐ Condom A4349 ☐ Foley A4338 (Bundle A4314)

☐ 10 fr ☐ 12 fr ☐ 14 fr ☐ 16 fr

☐ 18 fr ☐ Other Condom catheter size ______ mm

Patient Supply Count:

Patient caths __________ times per day Foley patient caths __________ times per month

Accessories:

☐ Leg bag (2 per month) A4358

☐ 600 mL ☐ 1,000 mL

☐ Drain bag (2 per month) A4357

☐ 1,000 mL ☐ 2,000 mL

☐ Tray insertion kit (foley cath only, 1 per foley) A4310

☐ Other: ______________________

Please attach the following (as applicable):

☐ Patient demographics sheet ☐ Copy of patient's insurance card

☐ Clinical Office Visit Note (from medical records of patient, documenting requirement for equipment as well as physician's assessment and expected benefit from the equipment ordered above. Physicians are required to sign and date notes.)

Practitioner name: ______________________

Address: ______________ Phone: __________ NPI: __________

Practitioner signature: ______________ Date: __________