Wheeler's MEDICAL SUPPLY LLC

PHYSICIAN'S WRITTEN ORDER:

STEP 1 Complete this Referral Form

STEP 2 Attach patient's demographic sheet and any supporting medical records

STEP 3 **Fax Form to: (904) 992-4662**

14603 Beach Blvd. STE 750-8 Jacksonville, FL 32250 Toll Free: (844) 992-8186 Fax: (904) 992-4662 ***All Fields Are Required To Process An Order***

PATIENT

First:_____ Last: :_____ MI: ____ Patient DOB: ___ /___ / _____ Gender: ☐ M ☐ F

Address: _____ Phone: _____ Alternate Phone: _____

City: _____ State: _____ ZIP_____ Email: _____

DIAGNOSIS

PLEASE SELECT ALL THAT APPLY:

☐ Permanent Urinary Retention / R33.9
☐ Permanent Urinary Incontinence / R32
☐ BPH w/ Obstruction / N40.1
☐ Neurogenic Bladder / N31.9

Other _____

INSURANCE

Primary Insurance: _____
Policy/ID: _____
Group: _____ Phone: _____
Secondary Insurance: _____
Policy/ID: _____
Group: _____ Phone: _____

PLEASE FILL IN ALL NECESSARY INFORMATION *FOR MEDICARE PATIENTS, PLEASE INCLUDE MEDICAL RECORDS*

DISPENSING ORDER INFORMATION

1. **Duration of need:** _____months (99 = Lifetime) **Please specify if the patient has latex allergy** ☐ Yes ☐ No

2. **Intermittent Catheters:** Is the condition Permanent (greater than 3 months)? ☐ Yes ☐ No ☐ **90 Day Supply**

☐ Straight (A4351)
☐ Coude* (A4352)
☐ Closed System (A4353)

French Size _____
Length _____

Qty / Day: _____ Qty / Month: _____

☐ Lubricant Packets (A4332)
☐ Lubricant Tube: (A4402)

Qty / Day: _____ Qty / Month: _____

3. Male External Catheters: Size _____ ☐ Quantity 35 ☐ Quantity per Month _____

*Each setup to include the following accessories (as needed): Insertion tray, Lubrication, Ext. tubing, Leg Bag, Drain Bag, Swab Sticks (alcohol/betadine), Sodium Chloride (500/1000ml), Lubricant, Drain Valves, Gloves, and Syringes.

☐ **Enroll patient in the manufacturer's support program.**

Start Date: ___ /___ / _____

***Other Supplies (if needed):** Item Number / Description

Qty / Day: _____ Qty / Month: _____

DOCTOR

Office Address: _____ Phone: _____ Fax: _____

Physician:	NPI #:	Physician:	NPI #:
☐ _____	# _____	☐ _____	# _____
☐ _____	# _____	☐ _____	# _____
☐ _____	# _____	☐ _____	# _____
☐ _____	# _____	☐ _____	# _____

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate, and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed, and physician notes and other supporting documentation will be provided to Wheeler's Medical Supply, LLC upon request. I understand any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

PHYSICIAN SIGNATURE:_____

PHYSICIAN NAME: _____

DATE: _____ **(STAMPS ARE NOT ACCEPTABLE)**

RN or MA : _____