CathetersPLUS™/MC

(877) 563-7422 (844) 604-2322

info@cathetersplus.com • www.cathetersplus.com

Patient Referral Rx Form

Patient

First Name: **Last Name:**

Phone Number: **Email:**

Official Pharmacy Prescription

Medical Diagnosis:

Catheter Length: ☐ Male ☐ Female

Catheter Tip: ☐ Straight ☐ Coudé

Catheter Type: ☐ Intermittent ☐ Foley

Catheter Size: FR

Other Supplies Required:

Prescriber Name: ☐ MD ☐ NP

Prescriber Phone Number:

Prescriber Address:

Prescriber Signature: **Date:**

☐ Latex Allergy

☐ Follow-up nurse support for intermittent catheterization required

* ☐ Patient provides verbal consent to be contacted by CathetersPLUS™

Red Leaf Medical