CathetersPLUS™MC

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

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Patient Referral Rx Form

Patient

First Name: Last Name:

Phone Number: Email:

Address:

Preferred Language:

Medical Diagnosis:

Catheter Length: ☐ Male ☐ Female

Catheter Tip: ☐ Straight ☐ Coudé ☐ Flexible ☐ Elle™

Catheter Type: ☐ Hydrophilic ☐ Intermittent ☐ Foley

Catheter Size: FR

Instylan ☐ Number of Instillations (Weekly instillations of 4-12 weeks):

Notes/Other Supplies Required/:

Email for Referral Updates:

Prescriber Name: ☐ MD ☐ NP

Prescriber Email:

Prescriber Phone Number:

Prescriber Address:

Prescriber Signature: Date:

☐ Patient has an enlarged prostate

☐ Latex Allergy

☐ Follow-up nurse support required

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

Red Leaf Medical