

CathetersPLUS^{TM/MC}

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Patient Referral Rx Form

Patient

First Name:

Last Name:

Phone Number:

Email:

Address:

Preferred Language:

Official Pharmacy Prescription

Medical Diagnosis:

Catheter Length: Male Female

Catheter Tip: Straight Coudé Flexible ElleTM

Catheter Type: Hydrophilic Intermittent Foley

Catheter Size: FR Frequency:

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

Notes/Other Supplies Required:

Email for Referral Updates:

Prescriber Name:

Prescriber Title: 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 CathetersPLUSTM



Red Leaf
Medical