



**Summit Express
Medical Supply**

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Physician's Order For Intermittent Catheters

Patient Information:

Name: _____ Date of Birth _____

Address: _____ Apt/Suite _____

City: _____ ST: _____ Zip: _____

Phone: _____ Cell: _____

Diagnosis Code / Codes : _____

Length of Need (99 equals lifetime): _____

Catheter Size (Circle One) **6 Fr 8 Fr 10Fr 12Fr 14Fr 16Fr 18Fr** Other: _____ **Fr**
Type (Circle One) **Straight Tip Coude Tip**

Catheterization times per day: _____

Other Items (If applicable): _____

AUTHORIZING PHYSICIANS:

NAME: _____

Address: _____ **Suite** _____

City: _____ **ST:** _____ **Zip:** _____

Phone: _____ **Cell:** _____

Signature: _____ **Date:** _____

NPI: _____ **UPIN:** _____