



# Intermittent Catheter Prescription

Mayo Clinic Store

Form content not retained in medical record.

Route to Mayo Clinic Store for electronic storage.

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic or Store Account Number

**External Form Users:** Complete this document and fax to the Mayo Clinic Store.

**Internal Epic Downtime Form Users:** Complete this document and fax to the Mayo Clinic Store. Once Epic downtime processes are complete, reenter order into the EHR and send an Epic message to the Mayo Clinic Store's inbasket pool informing them that a duplicated order was created.

**Required:** Attach patient's current primary, secondary, and tertiary insurance providers and provider-signed clinical documentation verifying medical justification from face-to-face examination.

## Order Information

Order Date (mm-dd-yyyy)	Need Length <input type="checkbox"/> Lifetime <input type="checkbox"/> Other _____	Qualifying Diagnosis (ICD-10)
Patient Address (Street, City, State, ZIP Code)		Patient Phone

## Intermittent Catheters

<input type="checkbox"/> Intermittent urinary catheters; straight tip, with or without coating (Teflon, silicone, etc) (A4351) <input type="checkbox"/> Intermittent urinary catheter; coude tip, with or without coating (Teflon, silicone, etc) (A4352) <input type="checkbox"/> Intermittent urinary catheter; with sterile insertion supplies or kit (A4353) <input type="checkbox"/> Intermittent urinary catheter; straight tip, with hydrophilic coating (A4295) <input type="checkbox"/> Intermittent urinary catheter; coude tip, with hydrophilic coating (A4296) <input type="checkbox"/> Intermittent urinary catheter; with hydrophilic coating sterile insertion supplies or kit (A4297) <input type="checkbox"/> Lubricant, individual sterile packet, each (A4332) <input type="checkbox"/> Lubricant, per ounce (A4402)		
Comments		
Frequency of Use per Day	Total Dispense Quantity (frequency of use × days supplied)	Number of Refills

## Referring Provider Information and Signature

Facility	Phone	Fax
Provider Signature ▶	Date (mm-dd-yyyy)	
Provider Printed Name (First Middle Last)	National Provider Identifier	