Sound Health
Wound Management

Quick Start Program

Urology

CMN Order

Fax: 866-213-4464

Questions Please Call: 888-909-6863

Full Assignment Accepted

Patient Name:_____ Date:_____

Name of Clinic: _____ City: _____Phone:_____

Name of Nursing Home: _____City: _____ Phone: _____

In order for Sound Health to process your/a patient's order, we need the following documentation faxed:
*Copy of the **PATIENT FACE SHEET** *signed (**AOB**) (at bottom) ***ORDER SIGNED BY PHYSICIAN**

	Products	Size and Type	**Frequency of Use** (specify day week or month)	Quantity
	Intermittent Urethral Catheter (accessories: __Y, __N)	Red Rubber Plastic French____		
	Intermittent Catheter in a Bag	Red Rubber Plastic French____		
	Coude Intermittent Catheter (accessories: __Y, __N) Justification:_____	Plastic French_____		
	Male External Catheter	SM MED INT LG XLG		
	*Male External Catheter Specialty [Justification _____]			
	Bedside Drainage Bag 2000cc			
	Leg Bag	SM MED LG		
	Foley Catheter Type_____	5cc 30cc French_____		
	Foley Insertion Tray	10cc 30cc		
	Other:			
	Other:			

ICD-9 Diagnosis

Diagnosis: _____ Length of Need: 99-Lifetime unless other noted: other _____

Does Patient have a latex allergy? Yes ____ No____ Does patient have permanent urinary incontinence or retention? Yes____ No____

Does patient have UTI history? Yes____ No_____

Physician name: _____

Signature: _____ Date: _____

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to Sound Health Medical Supply for any supplies or services furnished to be by Sound Health Medical Supply. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home, opened or unopened, cannot be returned. I authorize any holder of medical information about me to release to Sound Health Medical Supply any information needed to determine benefits payable for these supplies or services. Further, I authorize Sound Health Medical Supply to forward my medical records to the medical professionals in my care and/or make copies of said records. I acknowledge that I have received the policies and procedures and HIPPA information from Sound Health.

Please Print

Patient's Name: _____ Date of Birth: _____ Social Security No: _____

Address: _____ Phone: _____

Patient's Signature: _____ Date: _____