

Male urinary incontinence

Request for funding

PATIENT INFORMATION

Last name	First name
Policy number	
Name of insurer	
Medical condition	
<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Benign Prostatic Hyperplasia
<input type="checkbox"/> Paraplegia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Bladder Cancer
<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Prostatectomy	_____

INSURER REQUEST INFORMATION

Dear Insurer,

My patient (named herein) has been assessed as requiring external catheterization for management of incontinence, as a consequence of his medical condition.

This patient has experienced the following, which had a negative impact on his health condition and quality of life:

Skin irritation

Scab

Urinary tract infections

Leakages

Other: _____

As a consequence, the products prescribed (see reverse side) are required for my patient.

We therefore request funding for these products.

PHYSICIAN INFORMATION

Name	License number
Clinic stamp	

ADDITIONAL INFORMATION

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PHYSICIAN SIGNATURE

DATE (MM/DD/YYYY)

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Rx INFORMATION

EXTERNAL CATHETERS

Conveen® Optima Standard

25 mm (#22025)

28 mm (#22028)

30 mm (#22030)

35 mm (#22035)

40 mm (#22040)

Conveen Optima Short

21 mm (#22121)

25 mm (#22125)

30 mm (#22130)

35 mm (#22135)

Other: _____

Repeats

Change every 24 hours

Other: _____

URINE BAGS

Conveen Active Leg Bag

250 mL/9 oz (#25501)

Conveen Leg Bag

500 mL/17 oz (#5161)

Conveen Leg Bag

750 mL/26 oz (#5167)

Conveen Night Bag

2 L/68 oz (#21346)

Other: _____

Monthly quantity

30 External Catheters

30 Leg Bags

30 Night Bags

Other: _____

Please attach quotation from dealer.

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