RX GEEWHIZ® IMD™

WITH INTEGRAL COLLECTION POUCH (ICP™)

Merlin Medical Supply Pharmacy
699 Mobil Ave. Camarillo, CA 93010
Phone: (800) 639-9323 Fax: (805)-389-8142

DATE:________FAXED BY:__________________________

PATIENT INFORMATION

PATIENT NAME:____
ADDRESS: ____
CITY:_________________________________STATE: _____ZIP: _______
TELEPHONE: (________)-________-___________
DATE OF BIRTH:____________

INSURANCE INFORMATION

MEDICARE ID#______________-______________-______________
MEDI-CAL ID#_________________________ ISSUE DATE:__________
INSURANCE CARRIER NAME:___________________________________
PRIMARY/SECONDARY ID#____________________________________
GROUP#_________

DIAGNOSIS (CIRCLE)

URINARY INCONTINENCE PROSTATITIS

OTHER (PLEASE SPECIFY):____

REFILL (CIRCLE): X 3 MONTHS X 6 MONTHS X 1 YEAR

ORDERING INFORMATION

GEEWHIZ SIZE (CIRCLE): 29MM 32MM 36MM

QUANTITY: NO. OF ATHETERS ___________

NOTE: AVERAGE MONTHLY USUAGE IS 30 CATHETERS PER MONTH)

LEG BAG: 19OZ - QTY: _______ 32OZ - QTY: _____

BEDSIDE DRAIN BAG: 2000CC - QTY: _______

(NOTE: AVERAGE MONTHLY USUAGE IS 1 LEG BAG & 1 BED BAG PER MONTH)

OTHER:______________________________________

PHYSICIAN INFORMATION

PHYSICIAN NAME:____
ADDRESS:____
CITY:_________________________________STATE: _____ZIP: _______
TELEPHONE: (________)-________-___________
FAX: (________)-________-___________

HAS THE PATIENT TRIED ANY OTHER TYPE OF CONDOM CATHETER? (CIRCLE ONE)

YES OR NO

IF YES, WHICH ONE? ____________________________

WHY DIDN'T IT WORK? (SKIN IRRITATION, FELL OFF, ETC.)________________

____

____

PHYSICIAN SIGNATURE: ___________________________**DATE:**________

FOR MEDICAL SUPPLIES OR PRESCRIPTIONS

I AUTHORIZE DIRECT PAYMENT TO MERLIN PHARMACY OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR MERLIN PHARMACY'S PROVIDED PRODUCTS OR SERVICES. I ALSO AUTHORIZE MY INSURANCE COMPANY(IES) TO FURNISH MERLIN PHARMACY ANY AND ALL INFORMATION FOR BENEFIT DETERMINATION. IF MEDICARE DENIES COVERAGE FOR ANY PRODUCT OR SERVICE, I ACCEPT FULL RESPONSIBILITY FOR PAYMENT AND AGREE TO MAKE TIMELY PAYMENT UPON BILLING.

I ALSO AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION (MEDICAL HISTORY, SERVICES RENDERED, TREATMENT) ABOUT ME TO BE RELEASED TO MERLIN PHARMACY. I WILL REVIEW THE NOTICE OF PRIVACY PRACTICES UPON RECEIPT OF MY INITIAL ORDER. NPP IS ALSO AVAILABLE ONLINE AT WWW.URINEDEVICE.COM

PATIENT/SPOUSE SIGNATURE: ____________________________________ **DATE:** __________

CUT ALONG DOTTED LINE TO SEPARATE SIZING CHART BEFORE USING.
SAVE PRESCRIPTION FORM FOR LATER USE

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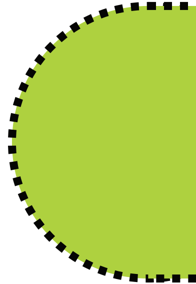
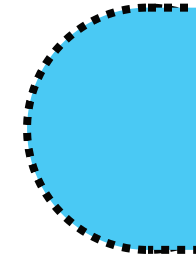
PR-L0028120110

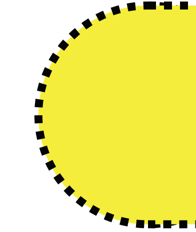
36 MM



32 MM



29 MM



Sizing Guide

Cut along dotted lines.

Place openings over penile shaft behind the glans or head of penis to select correct size.