



**Male External Urinary
Collection System**

Fax the completed form to:
888-920-9370

Patient

Name: _____

DOB: _____

Primary Phone: _____ Type: _____ Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Authorization to Contact:

I understand that my physician has referred me to the DME supplier named on this form for evaluation, provision, coordination, and billing of medically necessary equipment and supplies. I authorize the DME supplier and its representatives to contact me by telephone, voicemail, text message, email, or mail regarding my referral, insurance verification, equipment delivery, setup, training, maintenance, and related healthcare services. I understand that my protected health information may be shared between my physician, the DME supplier, and my health plan as permitted by applicable law for treatment, payment, and healthcare operations.

Patient Signature: _____ Date: _____

**MY PATIENT IS INTERESTED IN RECEIVING INFORMATION ABOUT THE
MEN'S LIBERTY MALE EXTERNAL URINARY COLLECTION SYSTEM.**

Clinician

Clinician: _____ Phone: _____ Fax: _____

NPI: _____ Credentials: _____ Document Generated By: _____

Facility name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____

Contraindications:

Absolute (When the product should not be used at all)

- Demonstrated sensitivity to hydrocolloid (rare)
- Anatomic abnormality (severe acquired hypospadias, urethral fistula, penile shaft erosions)
- Cannot retract foreskin to expose head

Relative (When the product can be used after healing)

- Unhealed wound at application site (wait to heal)
- Active rash at application site (wait to heal)
- Active inflammation or infection of the glans, prepuce or urethra (wait to heal)
- Purulent or bloody urethral discharge (wait to heal)



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