CathetersPLUS™

Patient Referral Program

PATIENT

First Name: _____ Last Name: _____

☐ Male ☐ Female

Phone # (BEST TIME TO CALL): _____ Email: _____

Address: _____

City: _____ Province: _____ Postal: _____

Catheter Insurance: ☐ Provincial ☐ Private ☐ None ☐ Other:

CLINICIAN

Clinician Name: _____

Clinician Signature: _____

Clinician Phone: _____ Clinician Email: _____

Note: _____

TYPE OF CATHETER/INCONTINENCE PRODUCTS:

☐ Hydrophilic	☐ Uncoated	☐ Foley	☐ Dilation
☐ Coudé tip	☐ Straight tip	☐ Anti-infective	☐ Briefs
☐ All silicone	☐ Leg bags	☐ Male external	☐ Pads

Catheter Size: _____ CH/FR

OSTOMY SUPPLIES:

Clinician – please attach list of recommended item(s) and product number(s).

☐ ***I agree to be contacted by CathetersPLUS™ staff to assist me in finding the right supplies for my needs.***

Patient/Legal Guardian Signature: _____

Date: _____

Please fax the form to the CathetersPLUS™ line at **905-569-7778** or email it to **info@redleafmedical.com**

If you should have any questions, please contact us at 1-877-563-7422.

Red Leaf Medical Inc.
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