BHSF Form DIP1
Revised 02/09

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Phone: ______________________________

Name: ______________________________ Date of birth: __________ Age: __________

Medicaid ID: ______________________________ Height: __________ Weight __________

Recipient's Address ______________________________

Prescribing Provider:

Prescriber's Name: ______________________________ Phone #: ______________

Address: ______________________________ Fax # ______________

➤ **Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD-9 CM code):**

Primary: ______________________ **Secondary:** ______________________

➤ **Specify Urine/Fecal incontinence diagnoses (Specify ICD-9 CM code):**

Primary: ______________________ **Secondary:** ______________________

➤ **Mobility**

- ☐ Ambulatory
- ☐ Minimal assistance ambulating
- ☐ Transfer Assistance
- ☐ Confined to bed or chair

➤ **Extraordinary Needs - if you are requesting more than 8 per day ONLY**
Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

➤ **Mental Status/Level of Orientation**

- ☐ Has the ability to communicate needs
- ☐ Sometimes communicates needs
- ☐ Unable to communicate needs

Frequency of anticipated change

During Day time (6 AM-10PM) _________.
During Night time (10PM – 6 AM) _______.

➤ **Additional supporting Diagnoses (Specific ICD-9-CM Code)**

____
____

Indicate current supportive services

- ☐ Home Health
- ☐ Skilled Nursing Services
- ☐ Personal Care Services
- ☐ Other ______________________

➤ **List any medications and/or nutritional therapy that would increase urine or fecal output:**

____

➤ **Specify incontinence supply, size, quantity/24 hours and duration of need:**

				Qty per day	Size (S, M, L, XL)
☐ Diapers (Check one):	☐ child size	☐ youth-sized	☐ adult-sized	________	________
☐ Pull-ups (Check one):	☐ child size	☐ youth-sized	☐ adult-sized	________	________
☐ Liner/shield (Check one):	☐ child size	☐ youth-sized	☐ adult-sized	________	________

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient's medical record.

Prescriber's Signature:

____

Date:

____

➤ **Comments**

____
____
____
____
____

☐ Additional documentation attached

NATIONAL TOTAL CARE SERVICES, LLC
115 Marcon Drive, Lafayette, LA 70507
(Phone) 337-291-9919 / (Fax) 337-291-9920 / (Toll-Free) 1-877-236-6687