Revised 06/18

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-10 CM code):**

Primary: _____ **Secondary:** _____

➢ **Specify Urine/Fecal incontinence diagnoses (Specify ICD-10 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-10-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**

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