BHSF Form DIP1
Revised 10/15

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

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 CM code):

Primary: _____ **Secondary:** _____

➤ Specify Urine/Fecal incontinence diagnoses (Specify ICD 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-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**