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-9 CM code):**

Primary: _____ **Secondary:** _____

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

Primary: _____ **Secondary:** _____

➤ **Mobility**

☐ Ambulatory
☐ Transfer Assistance
☐ Minimal assistance ambulating
☐ 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**