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
- ☐ 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 (Specify 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**