Revised BHSF Form DIP1
Issued 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 :

Primary: **Secondary:**

_____ _____

➤ Specify Urine/Fecal incontinence diagnoses :

Primary: **Secondary:**

_____ _____

➤ Mobility

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

➤ Extraordinary Needs

Supporting documentation for acute medical condition and/or extenuating circumstances for incontinence products (more than six per day).

➤ Mental Status/Level of Orientation

☐ Has the ability to communicate needs
☐ Sometimes communicates needs
☐ Unable to communicate needs
☐ Confined to bed or chair

Frequency of anticipated change

During Day time (6 AM-10PM) every _____ hrs.
During Night time (10PM – 6 AM) every _____hrs.

➤ Additional supporting Diagnoses

_____
_____

Indicate current supportive services

☐ Home Health
☐ Skilled Nursing Services
☐ Personal Care Services
☐ Other _____

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

_____
_____
_____

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**