

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 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

Frequency of anticipated change

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

➤ **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:**

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