# 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

## Additional supporting Diagnoses (Specific ICD-CM Code)

- ___________________________________________________________________________________
- ___________________________________________________________________________________

## 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:

- [ ] Diapers (Check one): [ ] child size [ ] youth-sized [ ] adult-sized Qty per day __________________ Size (S, M, L, XL) ____________
- [ ] Pull-ups (Check one): [ ] child size [ ] youth-sized [ ] adult-sized Qty per day __________________ Size (S, M, L, XL) ____________
- [ ] Liner/shield (Check one): [ ] child size [ ] youth-sized [ ] adult-sized Qty per day __________________ Size (S, M, L, XL) ____________

## Comments

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- [ ] Additional documentation attached