PHONE: 1.800.344.1550 FAX: 1.844.317.9377
EMAIL: orders@chcsolutions.com

INCONTINENCE ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: ______________________ DOB: ____/____/______ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: ____________

Patient cannot accept deliveries on the following days?
Mon Tues Wed Thur Fri Sat

Emergency Contact Name/Phone Number: ______________________

DIAGNOSIS

Primary Diagnosis (Incontinence Related Diagnosis)	**Secondary Diagnosis (Cause of Incontinence Diagnosis)**
ICD-10 Code: ____________	**ICD-10 Code:** ____________
*Non-Specified Codes will not qualify for Primary Diagnosis	

Patient Weight: ____________ Patient Waist Size: ____________

PRODUCT SELECTION

Products and Sizes	**Quantity Per Day**	**Total Quanity Dispensed**
Baby Briefs: ☐ Size 2 Under 18lbs ☐ Size 3 16-28lbs ☐ Size 4 22-35lbs ☐ Size 5 27-35lbs ☐ Size 6 35-45lbs ☐ Size 7 41lbs and over		
Baby Pull Up Training Pants Girls: ☐ Size 2 Under 34lbs ☐ Size 3 32-40lbs ☐ Size 4 38lbs and up		
Baby Pull Up Training Pants Boys: ☐ Size 2 Under 34lbs ☐ Size 3 32-40lbs ☐ Size 4 38lbs and up		
Youth Pull Ups: ☐ Small/Medium 38-65lbs ☐ Large/X-Large 65-125lbs		
Youth Briefs: ☐ Small 20-31in. waist		
Adult Briefs: ☐ Small 20-31in. waist ☐ Medium 32-44in. waist ☐ Large 45-58in. waist ☐ X-Large 58-64in. waist ☐ XX-Large 60-70in. waist ☐ XXX-Large 74-100in. waist		
Adult Pull Ups: ☐ Small under 34in. waist ☐ Medium 34-45in. waist ☐ Large 44-54in. waist ☐ X-Large 48-66in. waist ☐ XX-Large 60-80in. waist		
Liners: ☐ Regular ☐ Super		
Underpads: ☐ Disposable ☐ Reusable		
Gloves Non-Sterile (100 per box): ☐ Small ☐ Medium ☐ Large ☐ X-Large		
Other:		

Order Date: ____/____/____ **Length of Need:** ________ **months**

REFERRAL INFORMATION

Ref #: ____________

Practice Name: ______________________ Fax: ______________________

Office Address: ______________________ Email: ______________________

Phone: ______________________ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: ______________________

Physician Name: ______________ NPI#: __________ Phone: (_____)_____-______ Ext. _____

Physician Signature: ______________________ Date: ____/____/______

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

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*All sizes may not be covered by insurance.