a CHC Solutions Company

PHONE: 1.844.493.4013 FAX: 1.844.317.9378
EMAIL: orders@healthsourcemedicalsupply.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) **ICD-10 Code:** ______________________ *Non-Specified Codes will not qualify for Primary Diagnosis	**Secondary Diagnosis (Cause of Incontinence Diagnosis)** **ICD-10 Code:** ______________________

Patient Weight: ______________________ Patient Waist Size: ______________________

PRODUCT SELECTION

Products and Sizes	**Quantity Per Day**	**Total Quanity Dispensed**
Baby Briefs: ☐ Size 1 (8-12lbs) ☐ Size 2 (12-18lbs) ☐ 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: ☐ 2-3T (Under 34lbs) ☐ 3-4T (32-40lbs) ☐ 4-5T (38lbs and up)		
Baby Pull Up Training Pants Boys: ☐ 2-3T (Under 34lbs) ☐ 3-4T (32-40lbs) ☐ 4-5T (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 (32-46in. 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		
Underpads: ☐ Disposable (22″x36″) ☐ Reusable (34″x36″)		
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.