

****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: _____
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Patient Weight: _____ Patient Waist Size: _____

PRODUCT SELECTION

Products and Sizes	Quantity Per Day	Total Quantity Dispensed
Baby Tabbed: <input type="checkbox"/> Size 1 (8-12lbs) <input type="checkbox"/> Size 2 (12-18lbs) <input type="checkbox"/> Size 3 (16-28lbs) <input type="checkbox"/> Size 4 (22-35lbs) <input type="checkbox"/> Size 5 (27-35lbs) <input type="checkbox"/> Size 6 (35-45lbs) <input type="checkbox"/> Size 7 (41lbs and over)		
Baby Pull Up Training Pants Girls: <input type="checkbox"/> 2-3T (Under 34lbs) <input type="checkbox"/> 3-4T (32-40lbs) <input type="checkbox"/> 4-5T (38lbs and up)		
Baby Pull Up Training Pants Boys: <input type="checkbox"/> 2-3T (Under 34lbs) <input type="checkbox"/> 3-4T (32-40lbs) <input type="checkbox"/> 4-5T (38lbs and up)		
Youth Pull Ups: <input type="checkbox"/> Small/Medium (38-65lbs) <input type="checkbox"/> Large/X-Large (65-125lbs)		
Youth Tabbed Briefs: <input type="checkbox"/> Small (20-31in. waist)		
Adult Tabbed Briefs: <input type="checkbox"/> Small (20-31in. waist) <input type="checkbox"/> Medium (32-46in. waist) <input type="checkbox"/> Large (45-58in. waist) <input type="checkbox"/> X-Large (58-64in. waist) <input type="checkbox"/> XX-Large (60-70in. waist) <input type="checkbox"/> XXX-Large (74-100in. waist)		
Adult Pull Ups: <input type="checkbox"/> Small (under 34in. waist) <input type="checkbox"/> Medium (34-45in. waist) <input type="checkbox"/> Large (44-54in. waist) <input type="checkbox"/> X-Large (48-66in. waist) <input type="checkbox"/> XX-Large (60-80in. waist)		
Liners: <input type="checkbox"/> Regular		
Underpads: <input type="checkbox"/> Disposable (22"x36") <input type="checkbox"/> Reusable (34"x36")		
Gloves Non-Sterile (100 per box): <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large		
Other:		

Order Date: ____/____/____

Length of Need: _____ months

REFERRAL INFORMATION

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.

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.