CHC SOLUTIONS, INC.

**FAX: 1.877.299.7606**
**EMAIL: incoorders@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: _____

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 Tabbed Briefs: ☐ Size 1 (8-14lbs) ☐ Size 2 (12-18lbs) ☐ Size 3 (16-28lbs) ☐ Size 4 (22-37lbs) ☐ Size 5 (27-35lbs) ☐ Size 6 (35-45lbs) ☐ Size 7 (41lbs and over) | | |
| Baby Pull Up Training Pants Girls: ☐ 2-3T (20-35lbs) ☐ 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) | | |
| Adult Tabbed Briefs: ☐ Small (20-32in. waist) ☐ Medium (32-44in. waist) ☐ Large (44-56in. waist) ☐ X-Large (58-64in. waist) ☐ XX-Large (60-70in. waist) ☐ XXX-Large (65-94in. waist) | | |
| Adult Pull Ups: ☐ Small (20-28in. waist) ☐ Medium (28-40in. waist) ☐ Large (40-56in. waist) ☐ X-Large (56-68in. waist) ☐ XX-Large (68-80in. waist) | | |
| Liners: ☐ Regular | | |
| Underpads: ☐ Disposable (23"x36") ☐ Reusable (34"x36") | | |
| Gloves Non-Sterile (100 per box): ☐ Small ☐ Medium ☐ Large ☐ 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.



*Some sizes may not be covered by insurance.