INCONTINENCE SUPPLIES PRESCRIPTION FORM

Recipient Name: _____ Date of Birth: _____ Medi-Cal ID: _____

DX: Medical condition/diagnosis causing bowel or bladder incontinence:

___ Diabetes ___ Hypertension ___ Congestive heart failure ___ S/P CVA ___ Myocardial infarction

___ Dementia ___ Alzheimer's disease ___ Parkinson's disease ___ Genitourinary mental disorder

___ Multiple sclerosis ___ Parkinson's disease ___ Quadriplegia ___ Paraplegia ___ Hemiplegia / Hemiparesis

___ Cancer unspecified ___ Bladder cancer ___ Urinary Tract Disorder ___ UTI

___ Renal Disease ___ Cystitis ___ Neurogenic Bladder ___ Atonic Bladder ___ Overactive Bladder

Male DX: ___ BPH ___ Prostatitis ___Prostate Cancer

Female DX: ___ Genital Prolapse ___ Cystocele ___ Pelvic Relaxation

Other:_____

Type of urinary incontinence: □ Overflow □ Stress □ Urge □ Mixed □ Functional

Type of bowel incontinence: □ Nervous system pathology
□ Functional (for example, chronic constipation)

PRODUCT TYPE	QTY	INITIALS
DISPOSABLE BRIEFS / UNDERWEAR		
DISPOSABLE UNDERPADS		
DISPOSABLE LINERS		
REUSABLE PANTS		
WATERPROOF SHEET		
INCONTINENCE CREAM		
INCONTINENCE WASH		
DISPOSBLE NON-STERILE GLOVES		

Prescription valid for _____months.

Prescribing Physician's Verification (Physician Use Only)

I have reviewed my patient's medical records and the items requested above. I verify that I have physically examined the patient within the last 12 months and have established that this patient has a chronic pathologic condition which is causally related to his/her incontinence and that other treatment options are not appropriate to decrease or eliminate incontinence. I have prescribed the items described above which I have determined to be medically necessary for this patient. I will maintain a copy of this prescription in the recipient's medical record to meet Medi-Cal documentation requirements.

I further authorize the provision of listed and generically equivalent incontinence products for this patient should the requested item not be listed on the Incontinence Medical Supply List.

YES _X_ NO___

Physician's Name:_____

Address:_____

_____

Phone:_____ Fax: _____

Physician's NPI:_____

Physician's Signature:_____ Date:_____