Physician's Choice DME

1627 S. Central Ave., Glendale CA 91204 Tel: (805) 409-0600 Fax: (805) 497-0905

Incontinence Supplies Prescription Form

Patient's Name: _____

Address: _____

Telephone #: _____

Medi-Cal ID#: _____

Health Plan ID# _____

Date of Birth _____ Age: _____

Patient is incontinent of: Bladder Bowel Both

Type of Urinary Incontinence: Overflow Stress Urge Mixed Functional

Type of Bowel Incontinence: Nervous system pathology Functional (i.e. chronic constipation)

Medical condition/diagnosis causing bowel or bladder incontinence:

1. DX _____ ICD10 _____

2. DX _____ ICD10 _____

Incontinence Supply Order

Quantity/Month	Item/Size	Frequency of Use
T4521,T4522,T4523,T4524 x _____	Brief/Diaper S,M,L,XL	Up to _____ Changes Per Day
T4525,T4526,T4527,T4528 x _____	Protective Underwear S,M, L,XL	Up to _____ Changes Per Day
T4535 x _____	Belted Undergarment	Up to _____ Changes Per Day
T4535 x _____	Liner	Up to _____ Changes Per Day
T4541 x _____	Disposable Underpad	Up to _____ Changes Per Day
T4537 x _____	Waterproof Sheeting	Up to _____ Changes Per Day
A4927 x _____	Gloves	Up to _____ Changes Per Day
A4335 x _____	Incontinence Wash	Up to _____ Changes Per Day
A6250 x _____	Incontinence Cream	Up to _____ Changes Per Day
T4536 x _____	Reusable Underwear	Up to _____ Changes Per Day

Prescription is valid for _____12_____Months

Prescribing Physician's Verification

I have reviewed my patient's records and the items requested above. I verify that I have physically examined the patient within the last twelve months, and have established that this patient has chronic pathologic condition that is casually related to his/her incontinence. I authorize the items described above as medically necessary for the recipient. I will maintain a copy of this prescription in the recipient's medical record to meet Medi-Cal documentation requirements.

Physician's NPI/State ID Number **Physician's Telephone:** **Fax:**

Physician's Name & Address

Date : **Physician's Signature :**