inter phase
Partners In Healthcare

***Incontinence Prescription Form***

***Phone: 215-743-1100 & 800-344-1550 Fax: 215-743-0105***

**Patient Information** ******Please Attach Face Sheet w/ Patient demographics & Insurance Information******

Patient Name_____ **Male** ☐ **Female** ☐ Date of Birth_____

*Preferred Language*_____ Patient Cannot Accept Deliveries on the following days (circle) *Mon Tues Wed Thu Fri Sat*

| ***Primary Diagnosis*** | ***Secondary Diagnosis*** |
|---|---|
| *ICD-10 Code:*_____ | *ICD-10 Code:*_____ |
| **Non-Specified Codes will not qualify for Primary Diagnosis.* | |

Patient Weight_____ Patient Waist Size_____

| **Products** | **Quantity Per Day** | **Total Quantity Dispensed** |
|---|---|---|
| ☐ *Children Diapers* | | |
| ☐ *Children Pull Ups* | | |
| ☐ *Children Training Pants* | | |
| ☐ *Liners* | | |
| ☐ *Underpads* | | |
| ☐ *Adult Briefs* | | |
| ☐ *Adult Pull Ups* | | |
| ☐ *Infant Diapers* | | |
| ☐ *Other:* | | |

**Order Date** _____/_____/_____ **Start Date** _____/_____/_____ **Length of Need**_____ **Months** **# of Refils**_____

***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 maybe disclosed. I certify that my decision to prescribe this recommended product was based solely based on my determination of medical necessity set forth herein.***

Facility Name_____ Contact Person_____

Phone # _____ Fax#_____ Email_____

Address _____

Ordering Physician (Please Print)_____ NPI #_____ License #_____

**Physician Signature**_____ **Date** _____/_____/_____ Pecos Certified *(circle one)* *Yes* *No*