Physician Order for Incontinence Supplies

Patient Name:_____ **DOB:** _____
Address: _____ **Phone:**_____
_____

Date of Order:_____ **Length of Need:** _____

Diagnosis:

- **This patient is Urinary Incontinent (ICD-10-R32)**
- **This patient is Fecal Incontinent (ICD-10-R15.9)**

Incontinence Product Needed/Size:

- **I certify that this patient requires Pull-ups (Size:_____)**
- **I certify that this patient requires Diapers/Briefs (Size:_____)**
- **I certify that this patient requires Disposable liners/pads**
- **I certify that this patient requires Bed Pads**
- **I certify that this patient requires gloves to help with changing Incontinence Supplies**

Quantity:

- **Check box to allow orders up to the maximum allowed amount**
  (200 Pull-ups per month)
  (192 Diapers/Briefs per month)
  (150 Bed Pads per month)
  (192 Disposable liners/pads)
- **One pair of gloves is to be ordered for each change of Incontinence Supplies**
  Or
- **Other amount of Pull-ups, Diapers, Bed Pads (per month) _____**

Physician: _____
Address: _____
_____
Phone: _____
NPI: _____

Provider: Smith's Drugs
Address: 139 E Main Street
Forest City, NC 28043
Phone: 828-245-9215
Fax: 828-641-9677 / 828-245-1793

Physician Signature: _____ **Date:** _____