ARVADA PHARMACY MEDICAL SUPPLY

10382 Ralston Road
Arvada, CO 80004
(720) 707-2444 – Phone
(720) 707-2400 – Fax

PHYSICIAN PRESCRIPTION FORM – Incontinence Supplies

Please circle YES or NO to all supply

Patient : _____ **DOB** _____

Address : _____ **Phone** _____

Diagnosis Code _____

Length of Need: [12] Months [X] Lifetime [X] Renewal

			Quantity
Yes	**No**	**Briefs or Diapers or Liners disposable total:**	240
Yes	**No**	**Underpads Disposable (Chux)**	150
Yes	**No**	**Gloves Disposable**	2 boxes
Yes	**No**	**Incontinence Cream (Ointment)**	2 tubes(8 oz)

If the amounts are different, indicate the required amount

Yes	No	Briefs Disposable	_____
Yes	No	Pull-Ups Disposable	_____
Yes	No	Liners Disposable	_____
Yes	No	Underpads Disposable(Chux)	_____
Yes	No	Gloves Disposable	_____
Yes	No	Incontinence Cream (Ointment)	_____
Yes	No	Soap Body Wash	_____

DOCTOR'S NOTES: _____

_____

I, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment for this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and available upon request.

Physician's Signature : X _____ **Date** X _____

Physician's Name : _____ **NPI** _____ **Colorado License #** _____

Physician's Address : _____ **Phone** _____