PROMED DME

Toll Free: 1-844-693-6316
Fax Order To: 844-972-1531
Email Order To: Neworders@promed-dme.com

Incontinence Physicians Order Form: Chart notes must include the need for the supplies ordered

Rep: _____ **Referral Source:** _____

Patient Name: _____ Patient DOB: _____

Patient Phone: _____ Patient Email: _____

Insurance Policy: _____ ID#: _____

DIAGNOSIS (Check appropriate diagnosis below)

☐	R32 – Urinary Incontinence	☐	R15.9- Fecal Incontinence	☐	Other Primary Diagnosis: _____
☐	Duration of Need: _____ months (1-99 months; 99=lifetime)		Patient Height: _____		Patient Weight: _____

PRODUCT TYPES, SIZES and QUANTITIES

☐	Diapers/Briefs	☐	Size: _____	☐	Qty/Mo _____
☐	Pull-Ups	☐	Size: _____	☐	Qty/Mo _____
☐	Underpads	☐	Size: _____	☐	Qty/Mo _____
☐	Liners	☐	Size: _____	☐	Qty/Mo _____
☐	Gloves	☐	Size: _____	☐	Qty/Mo _____

PRESCRIBING PHYSICIAN INFORMATION

Name & Credentials _____ NPI _____

Signature _____ Signature Date _____

(Stamped signature not accepted)

Phone _____ Fax _____