Continuum
a CHC Solutions Company

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CONTINUUM CONNECT INCONTINENCE ORDER FORM

Please attach face sheet w/ patient demographics & insurance info*

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Patient cannot accept deliveries on the following days?
☐Mon ☐Tues ☐Wed ☐Thur ☐Fri ☐Sat

DIAGNOSIS

Primary Diagnosis
ICD-10 Code: _____

Secondary Diagnosis
ICD-10 Code: _____

Patient Weight: _____ Patient Waist Size: _____

PRODUCT SELECTION

Products and Sizes						Quantity Per Day	Total Quanity Dispensed
Baby Briefs	☐ Size 2(S) Under 16lbs	☐ Size 3(M) 16-28lbs	☐ Size 4(L) 22-37lbs	☐ Size 5(XL) 27-35lbs	☐ Size 6(XXL) 35lbs and up		
Youth Pull Ups	☐ Small/Medium 38-65lbs	☐ Large/X-Large 65-85lbs					
Pull Up Training Pants Girls	☐ Size 2 18-34lbs	☐ Size 3 34-40lbs	☐ Size 4 38lbs and up				
Pull Up Training Pants Boys	☐ Size 2 18-34lbs	☐ Size 3 34-40lbs	☐ Size 4 38lbs and up				
Liners	☐ One Size						
Underpads	☐ Disposable	☐ Reusable					
Adult Briefs	☐ Small 20-31in. waist	☐ Medium 32-44in. waist	☐ Large 45-58in. waist	☐ X-Large up to 64in. waist	☐ XXLarge 60-70in. waist		
Adult Pull Ups	☐ Small under 34in. waist	☐ Medium 34-45in. waist	☐ Large 44-54in. waist	☐ X-Large 48-66 in. waist			
Other:							

Order Date: _____/_____/_____
Start Date: _____/_____/_____

Length of Need: _____ months

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____/_____/_____

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 may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: _____/_____/_____