ActivStyle
an AdaptHealth company

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FAX COMPLETED FORM TO: 888-421-5639

If attaching patient demographic sheet, please add name & DOB

NEW CLIENT REFERRAL FORM - INCONTINENCE

INTERNAL USE

Rep Name/# ______

Ref # ______

Tracking ID # ______

Start Date: ______

CLIENT

Client Name ______ Parent/Caregiver Name ______ Phone ______

Address ______ City ______ State ______ Zip ______

Phone ______ Primary Language ______ DOB ______ Gender ______ Weight ______ Waist ______ Hip ______

Alternate/Emergency Contact (Required) ______ Height ______ Last Dr. Appt. ______

DOCTOR

Primary Care Physician ______ Credential (MD, DO, etc.) ______ Phone ______ NPI # ______

Ordering Physician ______ Credential (MD, DO, etc.) ______ Phone ______ NPI # ______

INSURANCE

Medicaid ID # ______ Medicaid Plan Name ______

Other Insurance ______ Policy ID # ______ Phone ______

Other Insurance ______ Policy ID # ______ Phone ______

Other Insurance ______ Policy ID # ______ Phone ______

Commercial policyholder information (if different from client):

Name ______ DOB ______ Gender ______

Relationship to Client ______

DIAGNOSIS

Diagnosis or cause for incontinence ______

Include all supporting or causal ICD-10 diagnosis(es) ______

If requesting products other than incontinence, provide medical reason for those products: ______

Type of incontinence: ☐ Light ☐ Medium ☐ Heavy ☐ Bladder ☐ Bowel

DISPENSING INFORMATION

Type of products requested:	**Quantity used per day:**	**Size of current product (if any), or additional notes about products requested.**
☐ Pull-on type briefs		
☐ Diapers		
☐ Bladder control pads		
☐ Underpads		
☐ Other ______		
☐ Other ______		
☐ Other ______		
☐ Other ______		

REF

Required

Contact Name ______

Facility ______ Phone ______

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