WeCare for AbetterU Medical Supply
Your body. Your journey. Our priority.

1130 Burnett Avenue, Suite B
Concord, CA. 94520
Phone: 925-463-5600
Fax: 925-307-5395

Incontinence Supplies

Please fax completed form to WeCare for AbetterU
at: Fax: 925-307-5395

PLEASE PROVIDE DEMOGRAPHIC AND INSURANCE INFORMATION.

Patient's Preferred Language ❑ English ❑ Spanish ❑ Russian ❑ Other _____ Gender ❑ Male ❑ Female

Recipient Name: _____ DOB: _____

Medi-Cal ID Number: _____Waist Size: _____ *Weight: _____

Address: _____Apt. _____City: _____ State: _____Zip Code: _____

Phone: _____Cell: _____ Email: _____

Provider Contact: _____ Telephone Number: _____

Emergency Contact: _____ Telephone Number: _____

Recipient Residence: ☐ Home ☐ Board and Care ☐ Other _____

Recipient is incontinent of ☐ Bowel ☐ Bladder

Medical condition/diagnosis causing bowel or bladder incontinence: _____

Type of urinary incontinence ☐ Overflow ☐ Stress ☐ Urge ☐ Mixed ☐ Functional

Type of bowel incontinence ☐ Nervous system pathology
☐ Functional (for example, chronic constipation)

Describe any previous treatments attempted and outcomes. Document reasons why other treatments drug, behavioral management or surgical intervention) are not appropriate: _____

_____

Prognosis for controlling incontinence: _____

_____

Brief summary of incontinence treatment plan: _____

_____

Document need and usage for multiple products. Explain need if requesting multiple varieties of supplies:

_____

_____

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NEED TAR?	PRODUCT TYPE AND BILLING CODE	DAILY USAGE	UNIT COST	MONTHLY USAGE	MONTHLY COST	TOTAL UNITS	TOTAL COST
	BRIEFS (ADULT DIAPERS) ❑ Small 20-32in. waist ❑Medium 33-47in. ❑Large 48-58in. ❑ X-Large 58-66in. ❑ XX-Large 60-70in.						
	PULL-UPS ❑ Small 20-29in. waist ❑Medium 29-41in. ❑Large 40-56in. waist ❑ X-Large 58-68in. ❑ XXL-Large 68-80in.						
	Women's Washable Reusable Underwear ❑ Small 20-28in. waist ❑Medium 26-32in ❑Large 28-36in. waist ❑ X-Large 32-38 in. ❑ XXL-Large 34-40 in.						
	Men's Washable Reusable Underwear ❑ Small 30-33in. waist ❑Medium 24-37in. ❑Large 38-41in. waist ❑ X-Large 42-45in. ❑ XXL-Large 46-48in						
	Liners (T4535) ❑ One Size						
	Underpads (T4541) ❑ One Size						
	Antimicrobial Cream (A6250) ❑ One Size						
	Antimicrobial Wash (A4335) ❑ One Size						
	Waterproof Sheeting (T4537) ❑ 39 X 75 inches						
	Gloves (A4927) ❑ Small ❑Medium ❑Large ❑ X-Large						

Prescription valid for ____months

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Prescription Physician's Verification (Physician Use Only)

I have reviewed my patient's records and items requested above. I verify that I have physically examined the patient within the last 12 months, and have established that his patient has a chronic pathologic condition that is causally related to his/her incontinence. I authorize the items described above as medically necessary for the patient. I will maintain a copy of this prescription in the recipient's medical record to meet Medi-Cal documentation requirements.

Physician's Name and Address (please print or type).

Physician's Telephone No.: Physician's Medi-Cal No.: Physician's Signature: Date:

Physician's Signature: _____Date: _____/_____/_____