StaySure™

Prescription - Physician Order

Fecal Incontinence Insert

PATIENT INFORMATION	
***Name:**	Gender: ☐ M ☐ F
***Date of Birth:**	***Phone #:**
***Street Address:**	Email:
***City, State, Zip:**	

PRESCRIBED STAYSURE PRODUCT

The StaySure™ Fecal Incontinence Insert (single-use, disposable) is being prescribed for management of fecal incontinence. Unless specified, the patient will trial provided samples to determine the most appropriate size. The patient will begin with the Standard size; if effective, they will continue with this size. If the Standard size is not effective, the patient will transition to the Large size.

☐ StaySure – Standard 30/bx REF#110104	☐ StaySure – Large 30/bx REF#110106

Length of Need:		Permanent Fecal Incontinence (90 days or greater):	
☐ Indefinite	☐ _____ Years	☐ Yes	☐ No

ICD9/ICD10 Diagnosis

☐ 787.60/R15.9 Full incontinence of feces	☐ 787.62/R15.1 Fecal smearing
☐ 787.61/R15.0 Incomplete defecation	☐ 787.63/R15.2 Fecal urgency
☐ Other	

PHYSICIAN INFORMATION

I have reviewed the patient's medical records and the items requested above. I verify the patient's medical condition requires the supplies described and that the usage quantities are medically reasonable and necessary. I will maintain a copy of this prescription in the patient's file to comply with the carrier's requirements.

***Physician's Name:**	***Physician's Phone #:**
***Facility Name:**	
***Facility Address:**	
***NPI #:**	***License #:**
RN/LPN Name:	Email:
***Physician's Signature:**	***Date:**

***Required Fields**

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