StaySure™

Fecal Incontinence Insert

Prescription - Physician Order

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

Rx: StaySure™ FECAL INCONTINENCE INSERT			
Sig: Patient to self-trial sizing using evaluation kit prior to supply selection. Patient will begin with the Standard size; if effective, continue use. If not effective, transition to the Large size to determine optimal fit for ongoing management of fecal incontinence.			
☐ Dispense Evaluation Kit (includes Standard + Large sizing devices) ☐ Evaluation Kit previously dispensed in clinician office			
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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