Referral Form

Tranquility® Incontinence Products

Please assist the Medical Assistant client with choosing a Tranquility product offered under their individual state Medicaid plan. Thank you.

Client Information

Client Name________________________ Caregiver Name____________________________

Address______________________________ City________________ State_____ Zip______

Phone______________________ Date of Birth__________ Height________ Weight________

Email____

Physician Information

Doctor's Name__________________________________ Phone______________________
(Include credentials if known MD, DO, etc.)

Insurance Information

Medicaid ID #________________________

Other Insurance______________________ Policy ID #____________ Phone #_____________

Product Information

⇨Diagnosis and cause of incontinence:

⇨Type of incontinence: Light Medium Heavy Bladder Bowel

⇨Type of product requested	Quantity used per day	Size of current product
Disposable Underwear (Pull-on Style)	____________	________________________
Diapers	____________	________________________
Pad or Liner	____________	________________________
Underpads (Chux)	____________	________________________
Wipes	____________	________________________
Other	____________	________________________

Referred/Ordered by

Referral Source__________________________________ Phone______________________

Organization____________________________________ Email______________________

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