OSTOMY SUPPLIES STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

915 30th Avenue
Fairbanks**, AK 99701**
Phone: (907) 458-8912
Fax: (907) 458-8914

Patient Name, Address, Telephone & Insurance ID #:

(_____) _____ - _____ Ins ID #: _____

Patient DOB: ____/____/____ Sex: ____ (M/F)

We have been asked to provide the following supplies to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

Ostomy:

Date of Last Visit: _____ Length of Need (# of months): _____ 1-99 (99=life)

Diagnosis and Code:

☐ Ileostomy (Z93.2) ☐ Attention to Ileostomy (Z43.2) ☐ Colostomy (Z93.3) ☐ Attention to Colostomy (Z43.3)

☐ Urostomy (Z93.6) ☐ Attention to Urostomy (Z43.6) ☐ Other: _____

Pouches:

Ostomy Pouches _____ each/monthly ☐ 1 Piece System ☐ 2 Piece System ☐ Clear ☐ Opaque

Please Select: ☐ Drainable Pouch ☐ Closed End Pouch

Wafers (Barrier):

Wafers _____/monthly *(box amounts are not valid)* ☐ with flange Stoma Size: _____

Please Select: ☐ Cut to Fit ☐ Precut | ☐ Stomahesive ☐ Durahesive | ☐ Flexible ☐ Solid

Monthly Supplies: *(box amounts are not valid)*

☐ Deodorant, (A4394) 8oz/month	Other Qty ____
☐ Stomahesive Powder (A4371) 10oz/every 6mo	Other Qty ____
☐ Stomahesive Paste Tube (A4406) 4oz/mo	Other Qty ____
☐ Barrier Ring Flat, (A4385) 10/mo	Other Qty ____
☐ Barrier Ring, Convex (A4411) 10/mo	Other Qty ____
☐ Barrier Wipes (A5120) 150/6mo	Other Qty ____
☐ Adhesive Remover (A4456) 200/mo	Other Qty ____
☐ Tail closure/clamps (A4363) ____/mo	Other Qty ____
☐ Skin Barrier, Solid 4x4 (A4362) 20/mo	Other Qty ____
☐ Ostomy Belt (A4367)	Other Qty ____

Provider's Signature: _____ Date: _____ NPI: _____

Provider Name: _____ Telephone: _____