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**OSTOMY ORDER FORM**

**\*\*Please attach face sheet w/ patient demographics & insurance info\*\***

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
 Is the patient currently being seen by home health?  Yes  No Is the patient currently using Nutritional Supplements?  Yes  No  
 Language Pref.:  English  Spanish  Other: \_\_\_\_\_  
 Emergency Contact Name/Phone Number: \_\_\_\_\_

**DIAGNOSIS**

<b>Primary Diagnosis</b> ICD-10 Code: _____ <small>**Code must state the specific type of ostomy.</small>	<b>Secondary Diagnosis</b> ICD-10 Code: _____ <small>**Code must state the specific type of ostomy.</small>
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**TYPE OF OSTOMY**

Colostomy  Ileostomy  Urostomy

**PRODUCT SELECTION**

Check all products that apply	Quantity	Item #
1 Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable		
2 Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable		
Wafer (for 2 Piece Pouch) <input type="checkbox"/> Flat <input type="checkbox"/> Convex Stoma Size: _____		

**ACCESSORIES SELECTION**

**Quantity**

Bedside Urinary Drainage Bag <input type="checkbox"/> 2000 ml	
<b>Belt</b> (Securi-T and Convatec): <input type="checkbox"/> One Size	
<b>Belt</b> (Hollister): <input type="checkbox"/> Medium <input type="checkbox"/> Large	
Barrier Ring <input type="checkbox"/> 2" <input type="checkbox"/> 4"	
Stoma Paste <input type="checkbox"/> Securi-T <input type="checkbox"/> Convatec	
Skin Prep Wipes <input type="checkbox"/> One Box	
Barrier Strips <input type="checkbox"/> One Box	
Deodorant <input type="checkbox"/> 8 oz Bottle	
Adhesive Remover Wipes <input type="checkbox"/> One Box	
Waterproof Tape: <input type="checkbox"/> 1" <input type="checkbox"/> 2" <input type="checkbox"/> 4"	
Other:	

Length of Need: \_\_\_\_\_ months  
 Dispense Amount (select one):  30-day  90-day  
 Has the patient been educated on how to apply the system?  YES  NO

**\*The Medicare allowable is 20 Drainable Pouches or 60 Closed Pouches a month.**

**\*The Medicare allowable is 20 Wafers a month.**

**REFERRAL INFORMATION**

**Ref #:** \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Preferred Method of Contact?  Phone  Fax  Email  
 Contact Person: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_