2700 W Cypress Creek Rd
Suite B109
Fort Lauderdale, FL 33309

T: 1-888-720-2830
F: 1-888-251-0202

PATIENT ORDER FORM

Ostomy Order Form

PATIENT SECTION			
Patient Name:		**Start Date:**	
Gender:		**Date of Birth:**	
Primary E-mail:		**Mobile Number:**	
Shipping Address:		**Home Number:**	
		Work Number:	

PHYSICIAN SECTION

Step 1: Diagnosis Code (required):

☐ Z43.3 Colostomy ☐ Z43.2 Ileostomy ☐ Z43.6 Urostomy ☐ Other: ____________

☑ A4425 Drainable Pouch (20 per month / 60 per 3 months)	☑ A4419 Closed Pouch (60 per month / 180 per 3 months)
☑ A5057 One Piece Drainable Pouch (40 per month / 120 per 3 months)	☑ A4407 Skin Barrier Wafer/Flange (20 per month / 60 per 3 months)
☑ A4362 Skin Barrier Strips (20 per month / 60 per 3 months)	☑ A4409 Skin Barrier Wafer/Flange (20 per month / 60 per 3 months)
☑ A4406 Ostomy Paste (2 oz per month / 6 oz per 3 months)	☑ A4385 Skin Barrier Rings (20 per month / 60 per 3 months)
☑ A4394 Ostomy Deodorant (8 oz per month / 24 oz per 3 months)	☑ A4371 Ostomy Powder (1 oz per month / 5 oz per 3 months / 10 oz per 6 months)
☑ A5120 Protective Skin Barrier Wipes (25 per month / 75 per 3 months / 150 per 6 months)	☑ A4456 Adhesive Remover Wipes (50 per month / 150 per 3 months)
☑ A4367 Ostomy Belt (1 per month / 3 per 3 months)	☑ A4455 Medical Adhesive Remover Spray (2 oz per month / 8 oz per 3 months / 16 oz per 6 months)
☑ A4369 Ostomy Skin Barrier, Liquid (Spray, Brush, etc) (2 oz per month / 6 oz per 3 months)	☑ A4396 Ostomy Support Belt (2 per 6 months / 4 per 12 months)
☑ A6216 Gauze (60 per month / 180 per 3 months)	☑ A4404 Sure Seal Ring (10 per month / 30 per 3 months)
☑ A4364 Medical Adhesive Spray (4 oz per month / 12 oz per 3 months)	☑ A4452 Ostomy Tape (40 yards per month / 120 yards per 3 months)

Authorizing 99 refills. If otherwise, please specify: ___________________. (Cannot be PRN.)

The above information is true, accurate, and complete to the best of my knowledge. I confirm that the patient is/was treated by me, and is able to use the supplies prescribed. I verify that the patient's medical condition requires the supplies prescribed and that the usage quantities are medically necessary. I will maintain a copy of this order in the patient's file.

Physician:	**NPI #:**	**Phone Number:**	
Office Address:		**Fax Number:**	
PRESCRIBER SIGNATURE		**DATE**	

NO STAMP ON SIGNATURE LINE

WEB

Please include Medical Records & Insurance Information | Phone (8888) 720-2830 | Fax (888) 251-0202