Hart Medical Equipment

Please fax to: 248-353-4260

Questions call: 888-606-8778

Ostomy Supplies Rx

Order Date: _____ ❑ New Order ❑ Reorder Length of Need: _____ (*1-99 months*)

For office use only
Account #: _____
Document Type: Physician Order

Patient Name: _____ D.O.B.: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Sex: ❑ Male ❑ Female Insurance #: _____

Does the patient have a nurse making home visits? ❑ Yes ❑ No *If yes & patient has Medicare, please contact the nursing agency for supplies.*

Nursing Agency: _____ Phone: _____ Contact: _____

Medical Necessity

Note: Answers must be supported by information in the patient's medical record

Primary Dx (ICD-10 Code): Colostomy: ❑ K94.00 ❑ K94.03 ❑ K94.10 ❑ K94.13 ❑ Z43.3 ❑ Z93.3

Ileostomy: ❑ Z43.2 ❑ Z93.2 Urostomy: ❑ Z43.6 ❑ Z93.6

Location of ostomy: _____

Date of ostomy surgery: _____ Is irrigation required? ❑ Yes ❑ No

Condition of skin surface surrounding stoma: _____

Skin Barrier – Check One Option in Each Category

Needed for	Wear	Flange	Skin Barrier	Wafer
❑ Urine	❑ Standard (QTY 20 per month)	❑ Cut-to-fit	❑ Flat	❑ 4" x 4"
❑ Stool	❑ Extended (QTY _____ per month)	❑ Size: _____"	❑ Convex	❑ 6" x 6"

Frequency of change: _____

Pouch – Check One Option in Each Category

Needed for	Wear	Flange	Pouch	Filter
❑ Urine	❑ Standard (QTY 20 per month)	❑ Cut-to-fit	❑ Drainable	❑ Filter
❑ Stool	❑ Extended (QTY _____ per month)	❑ Size: _____"	❑ Faucet-type tap	❑ No filter
	❑ High Output (QTY _____ per month)		❑ Closed	

Frequency of change: _____

1-Piece Pouching System (Pouch & Barrier are Attached) – Check One Option in Each Category

Needed for	Wear	Flange	Skin Barrier	Pouch
❑ Urine	❑ Standard (QTY 20 per month)	❑ Cut-to-fit	❑ Flat	❑ Drainable
❑ Stool	❑ Extended (QTY _____ per month)	❑ Size: _____"	❑ Convex	❑ Closed

Frequency of change: _____

Accessories Needed

❑ Paste (QTY 4 oz. per month): ❑ Strips ❑ Tube
❑ Adhesive Spray (QTY 4 oz. per month)
❑ Powder (QTY 10 oz. every 6 months)
❑ Ostomy Belt (QTY 1 per month): _____ inches
❑ Deodorant (QTY _____ 8 oz. bottles per month)
❑ Flat Eakin Seals / Barrier Rings (QTY _____ per day x 30 = _____ per 30 days)
❑ Convex Eakin Seals / Barrier Rings (QTY _____ per day x 30 = _____ per 30 days)
❑ Protective Barrier Wipes (QTY 150 every 6 months)
❑ Adhesive Remover Wipes (QTY _____ per day x 30 = _____ per 30 days)
❑ Cleaner / Decrystalizer (QTY 16 oz. per month)

Additional Supplies Needed

Item(s)	Frequency of use (# per day/week/month)	Quantity Ordered (per month)
_____	_____ per _____	_____
_____	_____ per _____	_____
_____	_____ per _____	_____
_____	_____ per _____	_____

Physician Name: _____ NPI #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician Signature: _____ Date: _____
(No signature / date stamps)

All information documented on this form must also be documented in the patient's medical record.

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