Ostomy Prescription Form

Phone (888) 244-6321 Fax (800) 975-6321

REFERRING FACILITY	
NAME	
CITY/STATE	
PHONE	
FAX	
CASE MANAGER	

RX DATE:	
Patient's Name:	

Is this patient currently being seen by Home Health Services? Yes No

Is this patient allergic to latex? Yes No

✓	Item	Brand/Part #	Usage
	Ostomy Pouch - One Piece		
	Ostomy Pouch - Two Piece		
	Flange w/ Skin Barrier		
	Skin Barrier Paste		
	Skin barrier Powder		
	Skin Barrier Wafer Solid ***4x4*** ***6x6*** ***8x8***		
	Nighttime Urinary Drainage Bag		
	Bedside Urinary Drainage Bag		
	Adhesive Remover Wipes		
	Skin Prep Wipes		
	Tape ***Paper*** ***Cloth*** ***Poly***		
	Other:		

✓	Estimated Time of Need
	99 = Lifetime
	Other:____________________

✓	Diagnosis
	V44.3 - Colostomy
	V44.6 - Urostomy
	V44.2 - Ileostomy
	Other:

STOMA SIZE

NOTES

✓	PHYSICIAN'S APPROVAL
NPI #	
SIGNATURE	**X**

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Prism Medical Products, L.L.C. 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. I authorize any holder of my medical information to release to Prism Medical Products, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Prism Medical Products, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT'S SIGNATURE	**X**