HOME CARE DELIVERED®
Your Trusted Partner for Medical Supplies

Phone: **(866) 332-4193** ext. **6552**
Fax: **(888) 565-4411**
Email: **Refer@HCD.com**
Online: **HCD.com/Refer**

Ostomy Supply Order Form

Please make sure all sections are filled out and include patient demographics to ensure no delays.

STEP 1

Facility Name: ______________________________ Phone: ______________
Facility Fax: ______________ Clinician Name: ______________________________

Doctor / Prescriber:

Name: ____________________ NPI: __________ Name: ____________________ NPI: __________
Name: ____________________ NPI: __________ Name: ____________________ NPI: __________
Name: ____________________ NPI: __________ Name: ____________________ NPI: __________
Name: ____________________ NPI: __________ Name: ____________________ NPI: __________

By my signature below, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. For Medicare, Medicaid, or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Signature Physician Signature : ______________________________ Date: _____ / _____ / _____

STEP 2

Patient Information:

Please complete all patient information below and or attach a demographics page.

Patient Name: ______________________________ Gender: ☐ M ☐ F DOB: _____ / _____ / _____
Phone: ______________________ Alternate Phone: ______________________
Address: ______________________ City: ______________ State: _____ Zip: _______
Patient's Insurance Plan Name (Primary): ______________________ ID Number: ______________
Patient's Insurance Plan Name (Secondary): ______________________ ID Number: ______________

STEP 3

Is the Patient currently being seen by Home Health or Hospice? ☐ **Yes** ☐ **No**
Authorizations: The patient is requesting coordination of care: ☐ **Yes** ☐ **No**
The patient has chosen Home Care Delivered to assist in providing the requested care by either providing product, verifying insurance benefits, billing for services, or coordinating care should direct service not be an option.

STEP 4

Plan of Care:

Length of need: *99 = Lifetime unless otherwise indicated.* Other: ______________ Months: ______________
Primary Diagnosis: ☐ Z43.6 Urostomy ☐ Z43.2 Ileostomy ☐ Z43.3 Colostomy ☐ Other: ______________
Secondary Diagnosis: ☐ Colon Cancer ☐ Bladder Cancer ☐ Ulcerative Colitis ☐ Other: ______________
☐ Crohn's Disease ☐ Perforated Bowel ☐ Bowel Obstruction
Additional justification as found in medical records: ______________________________
Latex Allergy? ☐ **Yes** ☐ **No**

STEP 5

Recommended Ostomy Supplies:

Ostomy Pouch Requested Brand: ☐ Hollister ☐ Coloplast ☐ Convatec ☐ Securi-T USA	**Product #**	**Daily Frequency of Use**	**Qty/Month**
One-Piece Pouch: ☐ **Drain** ☐ **Closed** ☐ **Urostomy**			
Two-Piece Pouch: ☐ **Drain** ☐ **Closed** ☐ **Urostomy**			
Skin Barrier w/ Flange *(required with Two-Piece Pouch)*			

Accessories	**Daily Frequency of Use**	**Qty/Month**
☐ **Skin Barrier Wipe** ☐ **No Sting**		
☐ **Adhesive Remover Wipe** ☐ **No Sting**		
Rings: ☐ **2”** ☐ **4”**		
Deodorant/Lubricant		
Powder		
Paste		
Skin Barrier Strips/Arcs		
Night Drainage Bag		
Belt		
Other		

Supply Assessment:

Does the patient currently have any of the requested product/s at home? ☐ **Yes** ☐ **No**
If yes, list the quantity remaining of each product the patient currently has in the notes section

Additional Notes:

HCD Field Sales Account Representative: ______________________ Contact Number: ______________ Email: ______________