



Please fax to: 718-708-7259

Referral Number: _____

Referral Name, Address and Phone: _____

Ostomy Order Form

Required Information Face Sheet Attached

PATIENT INFORMATION:

▶Patient Name (Last, First): _____ ▶Date of Birth (MM/DD/YY): _____
 ▶Street: _____
 ▶City: _____ State: _____ Zip Code: _____
 ▶Phone Number: _____ Mobile Number: _____
 Language: English Spanish Other: _____ Email: _____
 ▶Primary Insurance: _____ ID# _____ Phone: _____
 Secondary Insurance: _____ ID# _____ Phone: _____

PLAN OF CARE:

▶Start Date: _____ ▶Length of need: 99=Lifetime unless otherwise indicated. Other: _____ Months
 Latex Allergy? Yes No
 ▶Primary Diagnosis: Z93.3 Colostomy Z93.6 Urostomy Z93.2 Ileostomy Other: _____
 Secondary Diagnosis: Colon Cancer Ulcerative Colitis Perforated Bowel
 Bladder Cancer Crohn's Disease Bowel Obstruction Other: _____
 Additional Justification: _____

RECOMMENDED SUPPLIES:

Ostomy Items	Brand Preference	Product #	Daily Frequency of Use	Qty/Mo
One-Piece Pouch: <input type="checkbox"/> Drain <input type="checkbox"/> Closed <input type="checkbox"/> Urostomy				
Two-Piece Pouch: <input type="checkbox"/> Drain <input type="checkbox"/> Closed <input type="checkbox"/> Urostomy				
Skin Barrier with Flange (required with 2-piece pouch)				
Accessories	Brand Preference	Product #	Daily Frequency of Use	Qty/Mo
Skin Barrier Wipe No-Sting (25/pk)				
Adhesive Remover Wipe No-Sting (50/bx)				
Rings: <input type="checkbox"/> 2" <input type="checkbox"/> 4"				
Deodorant, 8oz				
Powder: <input type="checkbox"/> Pectin 2 oz <input type="checkbox"/> Karaya 4.5 oz				
Paste, Pectin 1oz				
Skin Barrier Strips/Arcs				
Night Drainage: <input type="checkbox"/> Bottle <input type="checkbox"/> Bag 2000cc				
Belt: <input type="checkbox"/> Medium <input type="checkbox"/> Large				
Tape: <input type="checkbox"/> Paper <input type="checkbox"/> Pink <input type="checkbox"/> Cloth <input type="checkbox"/> 1" <input type="checkbox"/> 2"				
Other:				

NAME, NPI#	NAME, NPI#	NAME, NPI#
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Galaxy to send future Physician correspondence to: _____ Fax #: _____

Licensed Healthcare Provider's Acknowledgement: My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Galaxy Medical Supply regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

▶Licensed Healthcare Provider's Signature: _____ ▶Date: _____

Signature stamps are NOT acceptable

Date stamps are NOT acceptable

For more information, please call: 718-708-7258