



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: ☐ Drain ☐ Closed ☐ Urostomy				
Two-Piece Pouch: ☐ Drain ☐ Closed ☐ 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: ☐ 2" ☐ 4"				
Deodorant, 8oz				
Powder: ☐ Pectin 2 oz ☐ Karaya 4.5 oz				
Paste, Pectin 1oz				
Skin Barrier Strips/Arcs				
Night Drainage: ☐ Bottle ☐ Bag 2000cc				
Belt: ☐ Medium ☐ Large				
Tape: ☐ Paper ☐ Pink ☐ Cloth ☐ 1" ☐ 2"				
Other:				

NAME, NPI#	NAME, NPI#	NAME, NPI#
☐	☐	☐
☐	☐	☐
☐	☐	☐

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

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