GALAXY MEDICAL SUPPLY

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