

****Has Patient been notified of and chosen Lifecare Technology for this order?***

PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS WITH THE INITIAL ORDER

First Name:		Last Name:	
Street Address(No P.O. Boxes):			Phone:
City:	State:	Zip:	
Sex: M F	Ht:	Wt:	DOB:

REFERRAL INFORMATION

Name of Facility:	
Referral Contact:	Phone #:
Is Patient being seen by Home Health? <input type="checkbox"/> YES <input type="checkbox"/> NO	

INSURANCE INFORMATION:

Primary:	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other:
Name:	Address:		
City:	State:	Zip:	Phone:
Policy #:	Group #:		

DIAGNOSIS / ICD10 CODE:

Colostomy Z93.3 Ileostomy Z93.2 Urostomy Z93.6 Encounter for Ileostomy Z43.2 Encounter for Urostomy Z43.6

MANUFACTURER: HOLLISTER COLOPLAST CONVATEC SECURI-T

	Item #	Quantity	Frequency of Use
<input type="checkbox"/> One Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable <input type="checkbox"/> Urostomy			
<input type="checkbox"/> Two Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable <input type="checkbox"/> Urostomy			
<input type="checkbox"/> Flange with Skin Barrier (required for Two Piece Pouch)			
<input type="checkbox"/> Tape <input type="checkbox"/> 2" Cloth <input type="checkbox"/> 2" Medipore			
<input type="checkbox"/> Skin Prep Wipes (Box) <input type="checkbox"/> Regular <input type="checkbox"/> Sting Free			
<input type="checkbox"/> Adhesive Remover Wipes			
<input type="checkbox"/> Paste (2oz)			
<input type="checkbox"/> Strip Paste			
<input type="checkbox"/> Barrier Strips			
<input type="checkbox"/> Deodorant (8oz bottle)			
<input type="checkbox"/> Adhesive Ring size _____			
<input type="checkbox"/> Barrier Ring size _____			
<input type="checkbox"/> Wafer <input type="checkbox"/> 2" <input type="checkbox"/> 4"			
<input type="checkbox"/> Urinary Drainage Bag <input type="checkbox"/> 2000ml <input type="checkbox"/> 900ml			
<input type="checkbox"/> Cleaner/Decrystalizer 16 oz/Cleaner			
<input type="checkbox"/> Powder (1oz)			
<input type="checkbox"/> Ostomy Belt size _____			
<input type="checkbox"/> Other			
<input type="checkbox"/> Other			

I certify that this order is reasonable and medically necessary and not merely a convenience item or it is a mandated benefit. This document may serve as a verbal order and is also written in the patient's record. The forgoing information is true, accurate and complete. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**

Ordering Physician or Licensed Prescriber (Please Print) _____

Address _____ Phone _____ Fax _____

Signature _____ Date _____ NPI # _____

Length of Need _____ Months Start Date ____/____/____ End Date ____/____/____