LINK

Ostomy Prescription For Medical Supplies

BARD has joined BD | LIBERATOR MEDICAL

Patient Number:	**Address1:**	**State:**
Patient Name:	**Address2:**	**Zip:**
Patient DOB:	**City:**	**Discharge Date:**

Instructions: Please fill in all sections and fax back to 888.205.1558. Please call 800.550.3224 with any questions.
If you have any changes, please cross out, write in correction, sign and date it.

Section A — DIAGNOSIS

___ Colostomy Z93.3 / Z43.3 ___ Ileostomy Z93.2 / Z43.2 ___ Urostomy Z93.6 / Z43.6

Section B — PATIENT SUPPLIES

Select the products you are prescribing	Per Day Usage	Quantity you are prescribing
☐ Drainable Pouches	1x day	20 / mo.
☐ Closed Pouches	2x day	60 / mo.
☐ Skin Barriers with Flange	1x day	20 / mo.
☐ Skin Barrier Strips	1xd	20 / mo.
☐ Barrier Rings	1x day	20 / mo.
☐ Conformable Seals	1x day	20 / mo.
☐ Stoma powder	1x day	1oz. / mo.
☐ Ostomy Belt	1 / mo.	1 / mo.
☐ Secu-Rings	1x day	20 / mo.
☐ Skin Barrier Paste	1x day	4oz. / mo.
☐ Bedside Drainage Bag	2 / mo.	2 / mo.
☐ Skin Barrier Wipes	2x day	50 / mo.

WOUND CARE SUPPLIES DX Code: _____	Size	Indicate Daily Frequency	Indicate Dispensing Quantity
☐ Gauze Sponges			
☐ Gauze Rolls			
☐ Tape			
☐ ABD Pads			

Select the products you are prescribing	Per Day Usage	Quantity you are prescribing
☐ Deodorant	1xd	16oz / mo.
☐ Adhesive	1x day	4oz. / mo.
☐ Gauze pad for cleaning, 100	4x day	100 / mo.
☐ Stoma Cap	1x day	30 / mo.
☐ Micropore Tape	1.33 sq. in./day	2 rolls / mo.
☐ Osteo- EZ Vents	4x day	100 / mo.
☐ Filters	1x day	30 / mo.
☐ Drain Bottle	1 / mo.	1 / mo.
☐ Appliance Cleaner	1x day	16oz. / mo.
☐ Adhesive Remover	2x day	50 / mo.
☐ Irrigation Sleeves	1 / wk.	4 / mo.
☐ Irrigation Supply Set	1 / mo.	1 / mo.

OTHER DX Code: _____	Size	Indicate Daily Frequency	Indicate Dispensing Quantity
☐ Other Ref #			
☐ Other Ref #			
☐ Other Ref #			
☐ Gloves			

Section C — DURATION OF NEED: 99 months (lifetime) unless you specify otherwise here: _____

By my signature below, I am stating that the patient is/was being treated by me. All information contained on the Rehab Program Prescription For Medical Supplies form accurately reflects the patient's condition and the treatment regimen I prescribed. My medical records for this patient substantiate the prescribed use of products. I will maintain a copy of this signed original Rehab Program Prescription For Medical Supplies form in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

Section D — PHYSICIAN INFO

Name: Phone:
Address:
Fax:
NPI#:

Section E — PHYSICIAN SIGNATURE

Signature

Printed Name Date

Please initial and date all changes on form.
Please send a copy of your chart notes along with this request.