Ostomy 2-1-1

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OSTOMY SUPPLY INFORMATION SHEET

COMPLETE THIS FORM ENTIRELY AND PROVIDE IT TO THE SUPPLIER OF YOUR CHOICE

A. SURGERY INFORMATION

HOSPITAL NAME:_____

CONTACT NAME:_____

DATE OF SURGERY: _____

CITY/STATE:_____

PHONE:_____ FAX:_____

B. PATIENT INFORMATION

NAME:_____ DOB:_____

ADDRESS:_____

CITY/STATE:_____

INS NAME & ID:_____

PHONE:_____

C. OSTOMY TYPE

☐ COLOSTOMY ☐ UROSTOMY ☐ ILEOSTOMY ☐ OTHER:_____

D. OSTOMY INFO (SKIP TO SECTION E IF YOU HAVE ITEM NUMBERS)

PREFERRED BRAND:_____ 1-PIECE OR 2-PIECE:_____ DRAINABLE: Y/N STOMA SIZE:_____

CLEAR OR OPAQUE:_____ CONVEXITY: Y / N

E. PRODUCT INFORMATION

BRAND:_____

☐ 1-PIECE ☐ 2-PIECE

POUCH ITEM #:_____

☐ DRAINABLE ☐ NON-DRAINABLE

BARRIER ITEM #:_____

F. OSTOMY ANCILLARIES REQUESTED

☐ DEODORANT:_____ ☐ ADHESIVE REMOVER:_____

☐ SKIN PREP:_____ ☐ STOMA PASTE/STRIPS:_____

☐ CLEANSER:_____ ☐ Y/D-STRIPS:_____

☐ BARRIER RINGS:_____ ☐ OSTOMY POWDER:_____

☐ OTHER: _____

G. QUANTITIES REQUESTED (HOW MANY OF EACH USED PER MONTH)

DRAINABLE APPLIANCE: ☐ 20 ☐ _____ NON-DRAINABLE APPLIANCE: ☐ 30 ☐ 60 ☐ _____

H. SHIPPING FREQUENCY REQUESTED

☐ MONTHLY ☐ 90-DAYS

I. NOTES:_____

_____

_____

PHYSICIAN NAME:_____ TELEPHONE:_____

FORM COMPLETED BY:_____ TELEPHONE:_____

(Please Print)

SIGNATURE:_____ DATE:_____