PLEASE FILL OUT THE ENTIRE FORM AND INCLUDE THE PATIENT'S DEMOGRAPHIC TO **AVOID DELAYS** .

PRISM Home Medical Supply Specialists

PHONE: (888) 244-6421
FAX: (800) 975-6321
WWW.PRISM-MEDICAL.COM

(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT NAME: ______________________ ***ORDER START DATE:*** ___ /____/_____
PATIENT PHONE: ______________________ PATIENT DOB: ______/_______/______
REFERRAL FACILITY: ______________________ CITY:__________________ STATE:____
REFERRAL PHONE: ______________________ FAX: ______________________

(SECTION 2) PLAN OF CARE REQUIRED

LENGTH OF NEED: *99 = LIFETIME UNLESS OTHERWISE INDICATED.* OTHER: __________________MONTHS

PRIMARY DIAGNOSIS: ☐ Z93.6 UROSTOMY ☐ Z93.2 ILEOSTOMY ☐ Z93.3 COLOSTOMY ☐ OTHER: ____________

SECONDARY DIAGNOSIS: ☐ COLON CANCER ☐ BLADDER CANCER ☐ ULCERATIVE COLITIS
☐ OTHER: ______________________ ☐ CROHN'S DISEASE ☐ PERFORATED BOWEL ☐ BOWEL OBSTRUCTION

ADDITIONAL JUSTIFICATION AS FOUND IN MEDICAL RECORDS: ______________________________

LATEX ALLERGY? ☐ YES ☐ NO **IS THE PATIENT RECEIVING HOME HEALTH SERVICES?** ☐ YES ☐ NO

(SECTION 3) REQUESTED SUPPLIES

OSTOMY POUCH	BRAND	PRODUCT #	QTY/MONTH
ONE-PIECE POUCH: ☐ DRAIN ☐ CLOSED			
TWO-PIECE POUCH: ☐ DRAIN ☐ CLOSED			
SKIN BARRIER W/ FLANGE (REQUIRED WITH 2-PIECE POUCH)			
UROSTOMY POUCH	**BRAND**	**PRODUCT #**	**QTY/MONTH**
ONE-PIECE POUCH: ☐ DRAIN ☐ CLOSED			
TWO-PIECE POUCH: ☐ DRAIN ☐ CLOSED			
SKIN BARRIER W/ FLANGE (REQUIRED WITH 2-PIECE POUCH)			
ACCESSORIES	**BRAND**	**PRODUCT #**	**QTY/MONTH**
SKIN BARRIER WIPE NO-STING (25/PK)			
ADHESIVE REMOVER WIPE NO-STRING (50/BOX)			
RINGS: ☐ 2" ☐ 4"			
DEODERANT			
POWDER			
PASTE			
SKIN BARRIER STRIPS			
BELT (PLEASE INDICATE SIZE) ______________			
OTHER:			

(SECTION 4) SUPPLY ASSESSMENT

DOES THE PATIENT CURRENTLY HAVE ANY OF THE REQUESTED PRODUCT/S AT HOME? ☐ **YES** ☐ **NO**

*IF **YES**, LIST THE QUANTITY REMAINING OF **EACH** PRODUCT THE PATIENT CURRENTLY HAS IN THE NOTES SECTION*

(SECTION 5) NOTES

(SECTION 6) AUTHORIZATIONS

IS THE PATIENT REQUESTING COORDINATION OF CARE? ☐ **YES** ☐ **NO**
(THE PATIENT HAS CHOSEN PRISM TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FORSERVICE(S) OR COORDINATING CARE SHOULD DIRECT SERVICE NOT BE AN OPTION.)

(SECTION 7) PROVIDER SIGNATURE

PROVIDER'S NAME:______________________________
PROVIDER'S NPI:______________________________
SIGNATURE:______________________________
DATE:_________/___________/____________

****(If the PROVIDER listed herein is best reached at a location other than the referring facility detailed in Section 1, please provide the PROVIDER'S contact information below.)***

PROVIDER PHONE: ______________________________
PROVIDER FAX: ______________________________

PRISM
HOME MEDICAL SUPPLY SPECIALISTS

Patient Demographics Form

Form must be filled out entirely to complete the patient file.

Patient Name: (First) (Middle Initial) (Last Name)
Please enter name as it appears on the insurance card.

Date of Birth: **Social Security Number**:

Address:

City: **State**: **Zip**:

Best Contact Number:

Shipping Address:

Same as Billing

Alternate Ship To Address:

City: **State:** **Zip:**

Primary Insurance:

Carrier Name:

Policy Number: **Group Number:**

Phone Number:

Secondary Insurance:

Carrier Name:

Policy Number: **Group Number:**

Phone Number:

Notes:

SUBMIT

Info Taken By: