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

PHONE: (888) 244-6421
FAX: (800) 975-6321
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(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

HAS THE PATIENT BEEN ASSESSED WITHIN THE PAST 6 MONTHS? YES NO IF YES, PLEASE PROVIDE DATE:______/______/______

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/BOX)			
ADHESIVE REMOVER WIPE NO-STRING (25/BOX)			
RINGS: 2" 4"			
DEODORANT/ODOR ELIMINATOR 8OZ			
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: ____________________________

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:

Info Taken By: