activelife medical products inc.

Please fax to: 209-926-9231
Email: Referrals@activelifemed.com
Phone : 800-319-2336

Ostomy Order Form

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

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.

Order by: _____ Phone Number: _____

Licensed Healthcare Provider's Acknowledgement: My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Active Life Medical regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

▸Licensed Healthcare Provider's Signature: _____ ▸Date:_____