bedard
Pharmacy & Medical Supplies ☑
Phone: 207-784-3700 | Fax: 207-795-7622

Ostomy Supplies Detailed Written Order

Fax this form and patient records to **207-784-7992**
Also available at **MyBedard.com/referral-forms**

1. Patient Information

Patient Name:_____ DOB:_____ Phone #:_____

Is patient currently in a facility? ☐ Y ☐ N If yes, Facility Name:_____ Facility Phone #:_____

Is patient currently being seen by home health? ☐ Y ☐ N

Has patient received any of the below supplies within the last 30 days? ☐ Y ☐ N

2. Provider Information

Provider Name:_____ NPI #:_____ Phone #:_____

Fax #:_____

3. Diagnosis Information

ICD-10 Code: ☐ Z93.3 Colostomy ☐ Z93.2 Ileostomy ☐ Z93.6 Urostomy

☐ Other:_____

4. Physician's Order & Authorization

Appliances	Quantity	Manufacturer Reference #	Length of Need	Frequency of Use	Refills
☐ One Piece Pouch ☐ Closed ☐ Drainable					
☐ Two Piece Pouch ☐ Closed ☐ Drainable					
☐ Wafer (Flange) **Required for a two piece system*					
Accessories					
☐ Adhesive Remover Spray					
☐ Adhesive Remover Wipes					
☐ Barrier Ring ☐ 2" ☐ 4"					
☐ Barrier Strips					
☐ Bonding Cement					
☐ Deodorant					
☐ Drainage Bag					
☐ Ostomy Support Belt					
☐ Powder					
☐ Skin Barrier Paste					
☐ Skin Barrier Spray					
☐ Skin Barrier Wipes					
☐ Other:					
☐ Other:					

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for ostomy supplies. I certify that I am the provider identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Provider Signature:_____ Date:_____