Physician's Order
OSTOMY SUPPLIES

Patient Information

Name:_____

Address:_____

City, State, Zip:_____

Medicare#:_____ DOB:_____

Phone: _____Height:_____ Weight: _____

PROFESSIONAL MEDICAL HOMECARE
4869-C MEMORIAL DRIVE
STONE MOUNTAIN, GA 30083
Phone: 404-292-9190
Fax: 404-608-9226
NPI Number: XX2287131

Diagnosis	Description
_____	_____
_____	_____

Length of Need[ ]_____ Months[ ]Lifetime_____

Please answer the following questions.

The quantity of ostomy supplies needed by a patient is determined to a great extent by the type of ostomy. Its location, its construction and the condition of the skin surface surrounding the stoma. There will be variation according to individual patient need and their needs may vary over time.

Based upon the above information, the following items are needed by this patient for the stated length need:

Date	Check Items(s)	Quantity	HCPC	Description
		1.00	A4430	UROSTOMY POUCH

1, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment from this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and are available upon request.

_____ _____
Physician's Signature: Date:

Physician Name:_____ NPI Number:_____

Address:_____ Phone Number:_____

City, State, Zip:_____ Fax Number:_____