TOTAL WOUND CARE SOLUTIONS
A Division of Tidewater Medical

OSTOMY ORDER FORM

Phone: (888) 858-9988
Fax: (866) 991-6282
www.tws.net

Patient Name: Fax:

Facility: Phone:

(Please include the ***Patient Information*** Sheet with the order form.)

Diagnosis

Diagnosis Required

Primary Diagnosis: □ **Colostomy V55.3** □ **Ileostomy V55.2** □ **Urostomy V55.6**
□ **Colostomy V44.3** □ **Ileostomy V44.2** □ **Urostomy V44.6**

Other: _____

Length of Need:

Is the patient currently being seen by Home Health? YES / NO

Products

MANUFACTURER □ **Hollister** □ **Convatec** □ **Coloplast** □ **Genairex** □ **Other**_____

Please Choose Size and Type Where Necessary	Item #	Quantity
□ One Piece Pouch □ Closed □ Drainable		
□ Two Piece Pouch □ Closed □ Drainable		
□ Flange w/ Skin Barrier (to use with the Two Piece Pouch)		
□ Skin Barrier □ Paste (2oz) □ Wipes (box of 25)		
□ Skin Barrier Wafer □ 4x4 □ 6x6		
□ Tape 1" 2" 3" □ Paper □ Cloth □ Waterproof		
□ Barrier Ring □ 2" □ 4"		
□ Night Urinary Drainage Collector		
□ Bedside Urinary Drainage Bag 2000cc		
Other:		

Doctor

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order, and I certify that the above prescribed supplies are medically necessary and reasonable.

Physician Name: _____ **NPI:** _____

Signature: _____ **Date:** _____

Patient

ASSIGNMENT OF BENEFITS

I request that all payments from any insurance carrier, including Medicare, Medicaid or private insurance company be made on my behalf to Tidewater Medical Inc (TWM) for any equipment, supplies or services provided to me by TWM. I authorize the release of my medical information to HCFA and/or my insurance carrier and its agencies for the purpose of review of healthcare benefits for the determination of payment. This authorization will remain in effect until written notification by myself or my legal representative has been received.

Patient Signature: _____ **Date:** _____