CONFIRMATION OF ORDER — Ostomy

PROVIDER: Home Health Solutions
501 East Sloan Street
Harrisburg, IL 62946

phone: 618-252-5349
fax: 618-252-2445

NPI: 1215337266
Tax ID #: 371124259

Patient: **Date of Birth:**

Order Date: **Insurance:**

Length of Need: 99 *(in months)*

Physician: **NPI:**

DIAGNOSIS

ICD 10 Code **Description**

PRESCRIPTION INFORMATION

Ostomy Type:

Ileostomy Urostomy Colostomy

Stoma Size:

(must have this information to process order)

Bag Type:

1-Pc 2-Pc w/Convex or w/o Convex w/Filter or w/o Filter

Standard Wear or Extended Wear Drainable or Closed End

Wafer Type: ***Only fill this out if choosing 2-Pc Bag***

Standard Wear or Extended Wear w/Convex or w/o Convex Cut to Fit or Pre-Cut

If patient can provide the item number (ref#) of product currently being used, please list below:

Item	Ref #	Qty
Bag	Ref #	Qty
Wafer	Ref #	Qty
Ostomy Deodorant (A4394)	Ref #	Qty
Stoma Paste (A4406)	Ref #	Qty
Ostomy Powder (A4371)	Ref #	Qty
Adhesive Remover Wipe (A4456)	Ref #	Qty
No Sting Wipe (A5120) or No Sting Spray (A4369)	Ref #	Qty
Ostomy Belt (A4367)	Ref #	Qty
Skin Barrier Strips (A4362) or Solid Skin Barrier (A4362)	Ref #	Qty
2” Conformable Seal (A4385) or 4” Conformable Seal (A4385)	Ref #	Qty

May Substitute or May Not Substitute

Refills:

Physician Signature: ______________________ **Date:** ______________