STANDARD WRITTEN ORDER FORM

Transmit by email: referrals@180medical.com or Fax: (888) 718-0633 or (405) 702-7709

★ **FOR MEDICARE PATIENTS, INCLUDE PROGRESS NOTES**

PATIENT

Patient Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient Phone Number: (_____)_____ - _____ Alt. Phone Number: (_____)_____ - _____

Date of Birth: _____ SSN: _____

Email: _____

INSURANCE

Primary: _____ Policy/ID #: _____ Group #: _____ Phone #: (____) ____-____

Secondary: _____ Policy/ID #: _____ Group #: _____ Phone #: (____) ____-____

DIAGNOSIS

☐ Ileostomy (Z93.2) ☐ Other (Please Specify) _____

☐ Colostomy (Z93.3) _____

☐ Urostomy (293.6) _____

ORDER

Date of Surgery: _____

Number of Refills ☐ 99 (lifetime) ☐ 12 (one year) ☐ Other _____

OSTOMY SUPPLIES				REQUIRED QTY to Dispense Per Month	REQUIRED Frequency Per Month	Product Number
One-Piece Pouch	☐ Drain	☐ Closed	☐ Urostomy			
Two-Piece Pouch	☐ Drain	☐ Closed	☐ Urostomy			
Skin Barrier	☐ Required with two-piece pouch					

Accessories

Adhesive Remover Wipe	☐ Box of 50					
Deodorant	☐ 8 oz					
Night Drainage	☐ Bottle	☐ Bag 2000cc				
Ostomy Belt	☐ One size					
Paste	☐ 2 oz tube					
Protective Barrier Wipes	☐ Box of 50					
Protective Powder	☐ 1 oz bottle					
Rings	☐ 2 in. (box of 20)	☐ 4 in. (box of 10)				
Solid Skin Barrier	☐ 4 x 4	☐ 4 x 8				
Tape/Barrier Strips	☐ Cloth	☐ Paper	☐ Pink			
	☐ 1 in.	☐ 2 in.	☐ Strips			

Required **Physician's Signature** Required **NPI #** Required **Date**

PHYSICIAN

Physican Name: _____ NPI#: _____

Office Name: _____ City: _____ State: _____ ZIP: _____

Office Address: _____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

Referred by: _____