NEW PATIENT PHYSICIAN ORDERS

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

****PLEASE INCLUDE PATIENT DEMOGRAPHICS****
****FOR MEDICARE PATIENTS, INCLUDE PROGRESS NOTES****

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ SSN: _____

PATIENT PHONE NUMBER: (_____)_____-_____ ALT. PHONE NUMBER: (_____)_____-_____

PLAN OF CARE

- ❑ Ileostomy (V44.2)
- ❑ Colostomy (V44.3)
- ❑ Urostomy (V44.6)
- ❑ Other (Please Specify) _____

Length of Need ..... ❑ 99 (lifetime) ❑ 12 (one year) ❑ Other _____

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

Ostomy Supplies				QTY to Dispense Per Month (Required)	Frequency Per Month (Required)	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	❑ Cloth	❑ Paper	❑ Pink			
	❑ 1 in.	❑ 2 in.				

❑ 90-Day Supply Authorized: Patient may receive up to a 3-month supply at patient's own choosing. Quantity to dispense will therefore be three times the monthly amount.

No Stamps _____ _____ Required _____

Physician Signature **NPI #** **Order Date**

Physician Name: _____

Office Name: _____

Office Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____

Referred by: _____