ADVANCED MEDICAL SOLUTIONS, INC.
"YOUR COMPLETE HOME MEDICAL EQUIPMENT COMPANY"
PHONE:517-548-1443 OPTION 5 FAX:517-548-1585

Ostomy – Written Order

Patient Name ____ DOB ____________ Account Number __________________

Order Date ________________ Length of Need, 99 (lifetime) or ________ months

Diagnosis ____

Pouch Options	**Quantity Needed**
☐ 1 Piece Closed Pouch	☐ ____ / month
☐ 1 Piece Drainable Pouch w/ Flat Wafer	☐ ____ / month
☐ 1 Piece Pouch w/ Convex Wafer	☐ ____ / month
☐ 2 Piece Pouch w/ Convex Wafer	☐ ____ / month
☐ 2 Piece Pouch w/ Flat Wafer	☐ ____ / month
☐ 2 Piece Closed Pouch System	☐ ____ / month
☐ Stoma Cap	☐ ____ / month
☐ Other ____	☐ ____ / month

Accessories	**Quantity Needed**
☐ Paste	☐ ____ / month
☐ Barrier Rings	☐ ____ / month
☐ Remover Wipes	☐ ____ / month
☐ Barrier Prep Wipes	☐ ____ / month
☐ Lubricating Deodorant	☐ ____ / month
☐ Belt	☐ ____ / month
☐ Barrier Strips	☐ ____ / month
☐ Other ____	☐ ____ / month

****Required For *MICHIGAN* Medicaid Patients Only ****
Reason for Medical Necessity (other than diagnosis): ____

Prescribers Printed Name & Credentials _______________________________ **NPI** _______________________

Phone ____ **Fax** ____

Signature ____ **Date** ___________________