

Patient Information (Required for Scheduling)

ICD-9

Patient Name: _____ DOB: _____ Sex: M F SS#: XXX-XX-_____

First & Last Name

Patient's Address: _____

Street

City

State

Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____

Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____

Plan & Product

WOCN Outpatient Services

Diagnosis: _____ (ICD-9 Code)

Ostomy Appliance Management

- Peristomal Ostomy Appliance Management for Ileostomy (V55.2)
- Peristomal Ostomy Appliance Management for Colostomy (V55.3)
- Peristomal Ostomy Appliance Management for Urostomy (V55.4)

Complications of Stoma

- Stoma Management for Gastrostomy (V44.1)
- Stoma Management for Ileostomy (V44.2)
- Stoma Management for Colostomy (V44.3)
- Stoma Management for Cystostomy (V44.50)

Incontinence

- Incontinence Urinary (V13.09)
- Incontinence Fecal (307.7)

Opened Wounds

- Non Healing Surgical Wound (998.83)
- Wound Vac Change < 50 sq cm (97605) (V58.30)
- Wound Vac Change > 50 sq cm (97606) (V58.30)

Other: _____

Physician orders:

Ostomy Nurse Care: Colostomy Ileostomy Ileal-Conduit Neobladder Urinary Incontinence

Fecal Incontinence Urinary Retention Teach Clean Intermittent Cath

Other: _____

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #: _____

I hereby certify that the services in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____



DeKalb Medical

FAX Orders to: 404.501.1025

Phone: 404.501.5109

Tax ID Number 58-1966795



P S - 1 0 8 6

**WOUND & OSTOMY CARE
ORDER FORM**

DMC FORM # PS-1086 (05/08/15)