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 herby 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

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WOUND & OSTOMY CARE ORDER FORM

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