Physician Visit Checklist©

Doctor Name: _____ **Office Number:** _____
Appointment Date/Time: _____ **Ostomy Prescription last filled:** _____
Reason for Visit: _____

Bring to visit:

- ❑ Current Ostomy Supply List
- ❑ Changes in Medical Conditions:

_____
_____
_____

- ❑ New Ostomy Supply Needs:

_____
_____
_____

Before leaving visit:

- ❑ Confirm the above is documented in medical record
- ❑ (If applicable) Get referral to a certified ostomy nurse

Questions/Concerns for this visit:

_____
_____
_____
_____
_____
_____
_____

List ostomy/stoma complications for letter of medical necessity (If applicable due to going over maximum allowable limit):

_____
_____
_____
_____
_____
_____

Confirm Prescription Order includes the following:

- ❑ Type of ostomy
- ❑ Diagnosis/ICD code (reason for ostomy)
- ❑ Estimated length of need
- ❑ Current insurance information
- ❑ Pouching System
  ___ 30-day supply
  ___ 90-day supply
- ❑ All item numbers for pouching system and accessories with brand
- ❑ Quantity for all items
- ❑ Physician Signature/Date (stamps are not acceptable)
- ❑ Letter of medical necessity

Advocates for a Positive Change www.ostomy.org 1.800.826.0826

UOAA United Ostomy Associations of America, Inc.