



CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD
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WINFIELD, KS 67156-0620
FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: (including cover page)

Phone:

Date:

RE:

Patient DOB:

OSTOMY ORDER

To Whom It May Concern:

Please review the following order and complete the information where the ➡ indicates

Also verify that all the information is correct or make corrections accordingly.

THANK YOU

Please complete the following:

Is the patient currently on Home Health

Doctor's Notes

Surgical Notes

Physician's Signature and the Date

And FAX to 620-221-7460

Thank you for your time and help

HAVE A GREAT DAY!

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

OSTOMY ORDER



Solving Problems / Delivering Solutions

901 Industrial Blvd, PO Box 620
Winfield, KS 67156
Phone: 620-221-0550
Toll Free: 800-362-1314
Fax: 620-221-7460

Patient Name: _____

Address: _____

City/ST/Zip: _____

Phone: _____

Start Date: _____ DOB: _____

Update of Order: _____

30 days dispensed for 12 months



Is this patient currently on Home Health? ☐ Yes ☐ No

If yes, Home Health Name: _____

Type of Ostomy: ☐ Ileostomy ☐ Colostomy ☐ Urostomy

Items to be dispensed per month:

1 piece system (bags): _____ Closed _____ Drainable

2 piece system (barriers and bags): _____ Barrier _____ Closed _____ Drainable

Ostomy Accessories:

_____ Barrier Seals _____ Strips _____ Paste _____ Powder
_____ Skin Prep _____ Adhesive Remover _____ Tape _____ Deodorant
_____ Ostomy Belt _____ Incontinent Wash _____ Stoma Lubricant

Urostomy Accessories:

_____ 4x4 Gauze _____ Leg Bag _____ Urinary Drainage Bag
_____ Irrigation Bag _____ Irrigation Cone
_____ Irrigation Sleeves _____ Lubricant



Physician Signature: _____ Date: _____

Physician's Name: _____ Fax #: _____

