OSTOMY, INCONTINENCE AND CATHETERIZATION SUPPLIES APPLICATION FORM

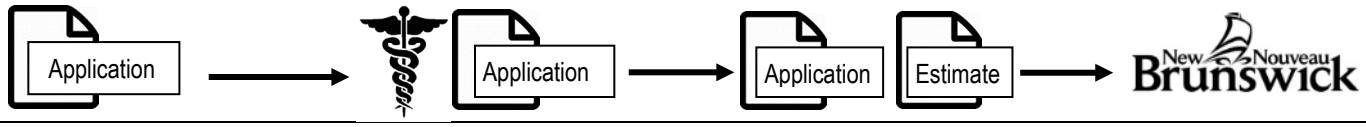
Social Development - Health Services, P.O. Box 5500, Fredericton, N.B., E3B 5G4 Toll Free: 1 (844) 551-3015 Fax: (506) 453-3960

The purpose of this form is to obtain enough medical information to determine eligibility for the Ostomy and Incontinence program delivered by ***Social Development - Health Services.***

The Application Process:

CLEAR / EFFACER

1. Client presents application to the prescriber.
2. Prescriber completes application and returns it to client.
3. Client brings application to Vendor and fills an estimate.
4. Send the two documents to Health Services for review.



CLIENT INFORMATION

Last Name	First Name, Middle Name	Date of Birth (DD/MM/YYYY)

Contact Number	Medicare Number	S.D. Health Card ID Number

The following sections 1, 2 and 3 must be completed by authorized prescribers only. All incomplete applications will be refused and returned to the client's case manager or social worker for follow-up, and it will cause a significant delay.

SECTION 1 – INDICATE THE MEDICAL CONDITION AND / OR DIAGNOSIS (Mandatory to prevent delays in processing)

OSTOMY BENEFITS – *Nurse practitioners and enterostomal nurses may prescribe the same benefits as physicians for this program.*

Date of surgery (DD/MM/YYYY): _____

Is this a **permanent** medical condition? ☐ Yes ☐ No

If answered no, please provide the anticipated or confirmed date for reversal (DD/MM/YYYY): _____

Does the client require incontinence, glove supplies to be used with the ostomy? ☐ Yes ☐ No

TYPE OF OSTOMY

☐ Colostomy ☐ Cecostomy ☐ Ileostomy ☐ Urostomy

☐ Other (details required): _____

TYPE OF APPLIANCE: ☐ One-piece appliance ☐ Two-piece appliance

CATHETER BENEFITS – *Nurse practitioners may prescribe the same benefits as physicians for this program.*

Date of surgery (DD/MM/YYYY): _____

Is this a **permanent** medical condition? ☐ Yes ☐ No

Does the client require incontinence, glove supplies to be used with these catheters? ☐ Yes ☐ No

TYPE OF CATHETERS

☐ In-dwelling ☐ External ☐ Intermittent

☐ Other (specify type):

INCONTINENCE / LAXATIVES BENEFITS - *Nurse practitioners may prescribe the same benefits as physicians for this program.*

1. Does the client require laxatives?	☐ Yes	☐ No
2. Does your client require incontinence supplies?	☐ Yes	☐ No
3. Is the client wheelchair bound?	☐ Yes	☐ No
4. Does the client have an ostomy or use catheters?	☐ Yes	☐ No

If you answered NO, to questions #3 and/or #4, please direct the client to contact the regional office for submission.

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SECTION 2 – PRESCRIBED PRODUCTS

This section lists the required products and must be completed by the authorized prescribers only: physicians, enterostomal therapist, urologists, nurse practitioners. **Incomplete forms will delay this client's application**.

I M P O R T A N T T O N O T E

Only list the products used in the direct management of the client's medical condition indicated on the application form.

Maximums quantities per month exist for all products paid through this program. In cases where quantities exceed monthly maximums, justification from a health professional will be required to consider exceptions.

All products have a **30-day time restriction** for pick up. Any requests for additional quantities of approved products within the same 30-day period must include medical justification from the client's health professional.

Product (Brand, size and other information)	Product Code	Quantity	Usage
EXAMPLE SenSura Mio Click drain pouch EXAMPLE	11492	20/mth	Monthly
EXAMPLE SpeediCath Coloplast 12 FR 10" EXAMPLE	28612	120/mth	Monthly
EXAMPLE Brava powder 25 g EXAMPLE	19075	1	Every 3 months
EXAMPLE Incontinent pad – 16x32 (disposable) EXAMPLE	N/A	30/mth	Monthly

Product (Brand, size and other information)	Product Code	Quantity	Usage

SECTION 3 - AUTHORIZED PRESCRIBER INFORMATION – ALL FIELDS ARE MANDATORY

PRESCRIBER'S STAMP (NAME and DESIGNATION)	PRESCRIBER'S INFORMATION	
	PRESCRIBER'S SIGNATURE:	
	TELEPHONE #:	
	FAX #:	
	DATE:	

AUTHORIZED PRESCRIBER: FORWARD COMPLETED APPLICATION TO A VENDOR BY CLIENT OR FAX
PHARMACY: SUBMIT APPLICATION AND COST ESTIMATE TO HEALTH SERVICES ON THE HEALTH SERVICES E-FORM.