### Physician Visit Checklist©

**Doctor Name:** ____________________________________________  **Office Number:** ____________________________________________

**Appointment Date/Time:** ____________________________  **Ostomy Prescription last filled:** ____________________________

**Reason for Visit:** ____________________________________________

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**Bring to visit:**
- [ ] Current Ostomy Supply List
- [ ] Changes in Medical Conditions:
  - ____________________________________________
  - ____________________________________________
  - ____________________________________________
- [ ] New Ostomy Supply Needs:
  - ____________________________________________
  - ____________________________________________
  - ____________________________________________

**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

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**Advocates for a Positive Change**  www.ostomy.org  1.800.826.0826

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