Finnegan HEALTH SERVICES

6805 W. 12th Street, Suite F
Little Rock, AR 72204
Toll-Free: **1-888-789-6600**
Fax: **501-663-6668**

Finnegan Ostomy Form

Patient Information

Last Date of Service ____/____/____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

Date of Birth: ____/____/____ Date of Surgery: ___/____/___

Type of Surgery: Colostomy Ileostomy Urostomy Stoma Size: _____ in/mm

DX Code -

Insurance Provider: _____

Enter product numbers* or Circle product options below:

_____

_____

Convexity: Yes or No **Pouch Color:** Opaque or Transparent **Filter** Yes or No

System: One-Piece or Two Piece *(20 Pouch) (20 Pouch Wafer)* **Pouch Closure:** Closed Drainable *(60 each) (20 each)*

Accessories: Belt - M or L *(1each)* Elastic Barrier Strip *(20 each)* Lubricating Deodorant *(8oz)*

Barrier Ring *(20 each)* Paste *(4oz)* Powder *(2oz)* Prep Wipe *(150 each)* Prep Spray *(2oz)* Strip Paste *(4oz)* *(not on Medicaid)*

**Item numbers are preferred*

Physician Name ‡: _____ Facility Name: _____

Refills: _____ 6 Medicaid _____ 12 Medicare

Physician Signature: _____ Date: _____

Fax: Send Ostomy Form to 1-501-663-6668

Email: Send Ostomy Form to wecare@finneganhealth.com

Website: Visit www.finneganhealth.com

Call: Contact Finnegan Consumer Care at 1-501-663-6600

Privacy Statement: Finnegan respects the privacy of your personal information and will protect the confidentiality of the information contained on this form. The only time the information may be used or shared is if it is (1) required by law; or (2) to provide you with information about Finnegan products, services and wellness education. You may be contacted by Finnegan, its agents, affiliates, contractors, or supply or service providers by telephone, email, US Mail, or other means of communication only for the purpose stated above. If you choose not to receive communication from Finnegan please contact us at 1-501-663-6668 or email: sam@finneganhealth.com to request communication be discontinued.

‡If this form has been completed by a healthcare professional, the healthcare professional acknowledges that he/she has read the above Privacy Statement to the patient and the patient consented.