

WOCN[®] Society Ostomy DME Provider Checklist

Patient Name/Address: _____

Patient Date of Birth: _____ Supplier Contact Information: _____

Allergy Alert: _____ Provider Name: _____ Phone: _____ No Substitutions: _____

Pouching System:

Stoma Information:

Number of stomas: _____

Reason for stoma: _____

Age of stoma: _____

Is stoma:

Permanent

Temporary

Size:

Flush

Protruding

Oval

Round

Ostomy Type:

Colostomy

Ileostomy

Urostomy

Other: _____

Brand Manufacturer:

Coloplast

Convatec

Cymed/Microskin

Hollister

Marlen

Nu-Hope

Other: _____

Pouch:

Product #: _____

Flange Size: _____

Quantity: _____

Per month: _____

Per 3 months: _____

Pouch Features:

Pouch System:

1 Piece

2 Piece

Color:

Transparent

Opaque

Closure/Outlet:

Drainable
(velcro or clip)

Closed-end

Tail/drain spout

Gas Management:

Integrated Filter

No Filter

Wafer/Barrier/Flange:

Product #: _____

Quantity: _____

Per month: _____

Per 3 months: _____

Pre-cut

Size: _____

Cut-to-fit

Size: _____

Moldable

Size: _____

Flat

Convex

Soft/Flexible

Light

Hard/Firm

Two-Piece:

Adhesive Coupling

Mechanical Coupling

Accessory Products:

Adhesive Remover

Wipes or Spray

Quantity: _____ Brand: _____

Barrier Strips

Quantity: _____ Brand: _____

Deodorizer

Quantity: _____ Brand: _____

Hernia Support Belt

Quantity: _____ Brand: _____

Irrigation Supplies

Quantity: _____ Brand: _____

Ostomy Support Belt

Quantity: _____ Brand: _____

Overnight Drainage Bag

Quantity: _____ Brand: _____

Overnight High Output Pouch

Quantity: _____ Brand: _____

Paste (Tube or Strip)

Quantity: _____ Brand: _____

Powder

Quantity: _____ Brand: _____

Skin Barrier Seals/Rings

Quantity: _____ Brand: _____

Tape

Quantity: _____ Brand: _____

Other: _____

Quantity: _____ Brand: _____

No Substitutions

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