# OSTOMY, INCONTINENCE AND CATHETERIZATION SUPPLIES APPLICATION FORM

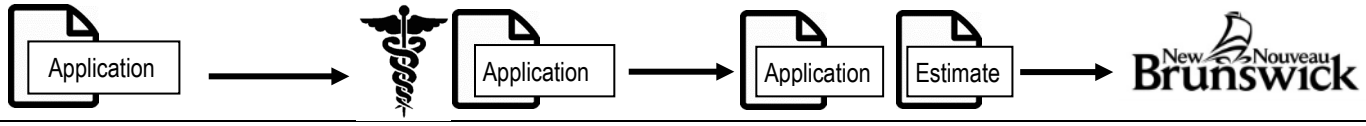
**Social Development - Health Services**, P.O. Box 5500, Fredericton, N.B., E3B 5G4 Toll Free: 1 (844) 551-3015 Fax: (506) 453-3960



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

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 *(To Be Completed By The Applicant)*

| 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 and INDICATE IF THE DIAGNOSIS IS PERMANENT OR TEMPORARY (12 months or less) *(Mandatory to prevent delays in processing)*

## OSTOMY BENEFITS – *Nurse practitioners, enterostomal nurses, EMP nurses, and other specialists 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, enterostomal nurses, EMP nurses, and other specialists 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, enterostomal nurses, EMP nurses, and other specialists 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 nurses EMP nurses, urologists, nurse practitioners. **Incomplete forms will delay this client's application**.

### IMPORTANT TO NOTE

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 |
|---|---|---|---|
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## 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.