



Patient details

1 Medicare number

2 Family name

Given name(s)

3 Address

Postcode

4 Ostomy association

Additional supplies requested

5	Product name	Code no.	Additional no. required each month *see restrictions below
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>

If insufficient room please attach additional page

6 Period required

7 Commencing Month Year

**In each instance where more than twice the maximum quantity is authorised, in addition to this form, a separate clinical justification is to be provided, stating the reason for the higher additional quantity. Where more than four times the maximum quantity is sought, approval from the Department of Health and Ageing is also required.*

Reason for increased supplies (appropriate box)

8 Retraction Bilateral stomas Altered physical condition Chemo/radiotherapy

Stenosis Fistula and stoma Prolapse Other

9 Additional information if required

10 Review date

Referring stomal therapy nurse / doctor details

11 Name

12 Location

13 Signature

14 Date

Association use only

Member entitlement number

Approval number