Client Name:

POST-OP OSTOMY MANAGEMENT PLAN

REFERRALS

NSWOC Date Signature	**Dietitian** Date Signature
Home/Community Care Date Signature	**To Social Worker** Date Signature

MANAGEMENT PLAN for _____ (indicate Ostomy or Mucous Fistula)

Initial Plan ☐ **Revision to Plan** ☐ if revision, then provide rationale for change

Pouching Concerns ☐ No ☐ Yes _____

Pouching System

☐ 1-Piece ☐ 2-Piece ☐ Flat ☐ Convex ☐ Concave ☐ Cut-to-Fit ☐ Pre-cut ☐ Shape-able ☐ Closed Pouch ☐ Drainable Pouch

☐ Other _____ Vendor/Product Numbers _____

Additional Ostomy Supplies

☐ Barrier Ring ☐ Strip Paste ☐ Paste ☐ Adhesive Remover ☐ Barrier Film ☐ Powder ☐ Anti-fungal Powder

☐ Belt ☐ Hernia Belt ☐ Pouch Deodorizer ☐ Leg Bag ☐ 2L Drainage Bag ☐ Drainage Bottle ☐ Other _____

Retail Store/Pharmacy (if applicable)

Plan (identify any other additional supplies needed) **Pouch Change Schedule**: _____

Discharge Supplies (include amount of each) _____

Date **Signature**

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First Nations Health Authority Health through wellness | fraserhealth Better health. Best in health care. | Interior Health | island health | northern health | Provincial Health Services Authority | Vancouver CoastalHealth | Providence HEALTH CARE | Yukon

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