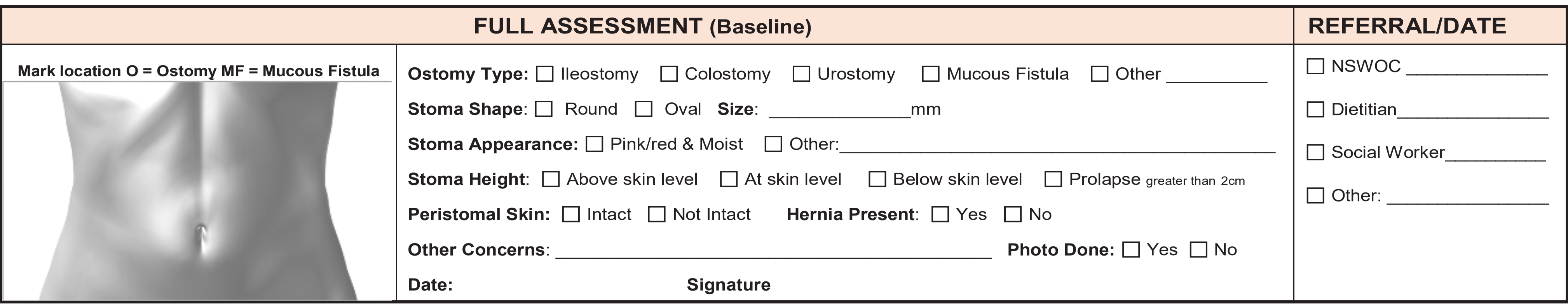
ESTABLISHED OSTOMY MANAGEMENT PLAN
Long Term Care

Client Name: ____________________

Established: at least 8 weeks post-surgery. Please fill out ONE form per Ostomy or Mucous Fistula

FULL ASSESSMENT (Baseline)

Mark location O = Ostomy MF = Mucous Fistula



Ostomy Type: ☐ Ileostomy ☐ Colostomy ☐ Urostomy ☐ Mucous Fistula ☐ Other __________

Stoma Shape: ☐ Round ☐ Oval **Size:** ____________mm

Stoma Appearance: ☐ Pink/red & Moist ☐ Other: ____________________________

Stoma Height: ☐ Above skin level ☐ At skin level ☐ Below skin level ☐ Prolapse greater than 2cm

Peristomal Skin: ☐ Intact ☐ Not Intact **Hernia Present:** ☐ Yes ☐ No

Other Concerns: ______________________________ **Photo Done:** ☐ Yes ☐ No

Date: **Signature**

REFERRAL/DATE

☐ NSWOC ____________

☐ Dietitian____________

☐ Social Worker__________

☐ Other: ____________

MANAGEMENT PLAN for ________________ (indicate Ostomy or Mucous Fistula)

☐ **Self-Care** ☐ **Partial Assistance** ☐ **Full Care**

Supplies add Vendor Name/Order Number (if known)

- ☐ Health Authority Ordering System
- ☐ Pharmacy/Retail Store__________________
- ☐ Flange______________________________
- ☐ Pouch ______________________________
- ☐ Barrier Ring: ________________________
- ☐ Adhesive Remover ____________________
- ☐ Ostomy Belt__________________________
- ☐ Urine Collection System ☐ Leg Bag ☐ 2L Bag ☐ Bottle
- ☐ Other:

See NSWOC Note as of date __________ **Pouch Change Schedule** __________ **Full Assessment due**__________

Date Initiated **Signature**

Date Changed **Signature**

ESTABLISHED OSTOMY MANAGEMENT PLAN
Long Term Care

Client Name: ____________________

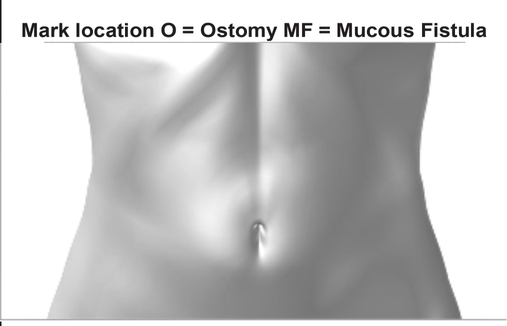
DOB: ____________________

PHN: ____________________

OR ADDRESSOGRAPH/LABEL Year: ________

FULL ASSESSMENT (Baseline)

Mark location O = Ostomy MF = Mucous Fistula



Ostomy Type: ☐ Ileostomy ☐ Colostomy ☐ Urostomy ☐ Mucous Fistula ☐ Other ________

Stoma Shape: ☐ Round ☐ Oval **Size:** __________mm

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Peristomal Skin: ☐ Intact ☐ Not Intact **Hernia Present:** ☐ Yes ☐ No

Other Concerns: ____________________ **Photo Done:** ☐ Yes ☐ No

Date **Signature**

REFERRAL/DATE

☐ NSWOC ________

☐ Dietitian ________

☐ Social Worker ________

☐ Other: ________

MANAGEMENT PLAN for ____________ (indicate Ostomy or Mucous Fistula)

☐ **Self-Care** ☐ **Partial Assistance** ☐ **Full Care**

Supplies add Vendor Name/Order Number (if known)

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- ☐ Pharmacy/Retail Store ________
- ☐ Flange ________
- ☐ Pouch ________
- ☐ Barrier Ring: ________
- ☐ Adhesive Remover ________
- ☐ Ostomy Belt ________
- ☐ Urine Collection System ☐ Leg Bag ☐ 2L Bag ☐ Bottle
- ☐ Other:

See NSWOC Note as of date ________ **Pouch Change Schedule** ________ **Full Assessment due** ________

Date Initiated **Signature**

Date Initiated **Signature**