Address

Date

To Whom It May Concern,

My Patient \_\_\_\_\_\_\_\_ has a permanent ostomy. This is a device to eliminate the bowel. This makes \_\_\_\_\_ markedly restricted in eliminating with this device as it takes an inordinate amount of time to personally manage bowel functions. In addition, personal management is very costly.

\_\_\_\_\_\_ surgery, an \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was performed at \_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_. She (he) is now 100% restricted in normal bowel functions due to the bowel cancer. Consequences of this operation resulted in bowel functions being performed via ostomy 100% of the time. This is a permanent way of living for \_\_\_\_\_\_\_, as the procedure cannot be reversed.

Day to day living with an ostomy means that she (he) spends at least six times as long as people without an ostomy. The time can include preparing and cleaning her skin and supplies, pouch changes every 3-5 days. Sometimes these appliance changes are required a lot sooner if an accident occurs, bowel movements (5-7 times daily), blockages, and elimination with irrigation.

Having an ostomy permanently restricts the ability to bend over correctly, and mobility is sometimes affected as pouch can sometimes “pop off”. It also restricts \_\_\_\_\_ from getting her rest and sleep as at least once and sometimes twice she (he) must get up to drain the pouch; leaving her (him) fully awake; interrupting her (his) sleep pattern.

If more information is required, please feel free to contact me at my office at \_\_\_\_\_\_\_\_\_\_\_\_,

Dr. \_\_\_\_\_\_ (address).

Thank you,

(Print full name of physician)

Signature of physician