



**Australian Government**  
**Department of Health and Ageing**

## STOMA APPLIANCE SCHEME

### Certification of Eligibility

(To be completed by an appropriate medical professional such as a Stomal Therapy Nurse)

Name of Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicare Number: \_\_\_\_\_

Type of stoma: \_\_\_\_\_  
*Colostomy/Ileostomy/Urostomy/Other(describe)*

Permanent / temporary (please circle one)

*The above person is eligible to receive products under the Stoma Appliance Scheme as they have a temporary or permanent artificial body opening (created surgically or otherwise) which facilitates the removal of urine and products of the gastrointestinal tract as this person does not have normal gastrointestinal tract or bladder functions.*

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Professional Title: \_\_\_\_\_  
*(Eg Stomal Therapy Nurse)*

Date: \_\_\_\_\_