Pelican Healthcare Ltd

Patient Registration Card

Pelican need to receive this completed form before we can register you onto the Home Delivery Service

ABOUT YOU

Title: Mr/Mrs/Master/Miss/Ms/Other (please state) ....

First Name: .... Surname: ....

Address: ....

.... Postcode: ....

Daytime Tel No: .... Date of Birth: ..../........./...........

Delivery Address (if different from above): ....

.... Postcode: ....

If you are not at home, is there somewhere safe we can leave your order? (eg. porch, shed, garage or with neighbour):

....

Do you have a: Colostomy: ☐ Ileostomy: ☐ Urostomy: ☐ Stoma size: .... mm

Would you like us to cut your pouches for you? Yes ☐ No ☐

Or tick here if you require them cut to a template ☐

Do you hold a Medical Exemption Certificate? Yes ☐ No ☐

If yes, please provide the following details:

Certificate No: .... Expiry Date: ....

HOSPITAL DETAILS

Who is your Stoma Care Nurse? ....

At which hospital did you have your operation? ....

When did you have your stoma operation? ....

GP DETAILS

GP's Name: ....

GP's Address: ....

....

Postcode: .... GP's Tel No: ....

Signed: .... Date: ....

FREEPHONE HELPLINE 0800 318 282

All information provided will be kept strictly confidential

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