

OUTPATIENT WOUND REFERRAL ORDERS

Wound/Ostomy Clinic

2801 DeBarr Road, 5th Floor • Anchorage, AK 99508 • Ph (907) 264-1583 • FAX (907) 264-2380

PATIENT: _____ DOB: _____ PH#: _____

PHYSICIAN: _____ ENROLLMENT DATE: _____

DIAGNOSIS: _____

Reason(s) for Referral: (check all that apply)

- ☐ Assessment, Evaluation, Wound Cleansing
- ☐ Debridement
- ☐ Negative Pressure Wound Therapy (Wound VAC)
- ☐ Lower Extremity Compression Therapy

Order:

Evaluate and Treat

Special Instructions:

Provider's Name (please print): _____

Provider's Signature: _____ Date: _____ Time: _____

* This order is valid for up to 6 months from date of signature

➤ *Please FAX this form to the Wound/Ostomy Clinic. The staff will contact the patient to set up an appointment. All patients must register in person in the Admitting Department prior to their appointment.*

Thank you for your referral to the Alaska Regional Hospital Wound/Ostomy Clinic. We appreciate your support of our program in an effort to provide the best care to the patients in our community.

ALASKA REGIONAL HOSPITAL
OUTPATIENT WOUND REFERRAL ORDERS
Wound/Ostomy Clinic



POS

Form: POS.WC.04 ej 5/12

SCANNED