ALASKA REGIONAL HOSPITAL

OUTPATIENT OSTOMY 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)**

- ❑ Pre-op stoma site marking Date surgery scheduled:_____
  - ❑ Ileostomy ❑ Colostomy ❑ Urostomy
- ❑ Assessment and treatment of stomal complications
- ❑ Assessment and treatment of peri-stomal complications
- ❑ Assessment and treatment of fitting for new ostomy appliance and ostomy appliance issues

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.