



Outpatient OSTOMY Clinic Referral

3/2024

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: ___ kg Height: ___ cm Allergies: ___ Diagnosis Code: ___
Treatment Start Date: ___

If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from the signature date of this order.

GUIDELINES FOR ORDERING:

- 1) The patient's name and date of birth must be at the top of this order form, it will be returned if left blank.
2) Send FACE SHEET and complete copy of INSURANCE information. If not available in Providence Epic, send H&P or the most recent chart note. This chart note must be within the past 12 months.

Ostomy referrals: Please select only ONE in this section.

- Patient already HAS an ostomy. Type of ostomy: ___ Reason for referral: ___ Wound Ostomy Continence (WOC) nurses to evaluate and treat PRN as condition mandates.
Patient NEEDS an ostomy. Pre & Post-op ostomy counseling & care with stoma site marking. Evaluate and treat PRN as condition mandates. Date of surgery: ___ Type of surgery/ ostomy: ___
Other: Please explain the request: ___

Miscellaneous: If applicable to patient.

- Colostomy irrigation teaching with volume: ___ (500-1500 ml is typical) of warm tap water.
Split thickness skin graft care (STSG care), as many visits as needed & to be coordinated with provider. If specific dates required, list here: ___

Standard included Nursing Orders:

- Vital signs PRN.
Provide patient education for selected treatment(s) above.
Unless otherwise directed, photographs may be taken as the condition requires & may be sent to the referring provider as needed.

Standard included Medication Orders: To be used as applicable per RN discretion.

- Silver nitrate applicator stick(s) topical PRN.
Miconazole (micatin) 2% powder topical PRN (for external use only).

By signing below, I represent the following:

I am responsible for the care of the patient (who is identified at the top of this form).

I hold an active, unrestricted license to practice medicine in Oregon.

My physician license number is # ___ and I am acting within my scope of practice and authorized by law to order the treatment and medications described above for the patient identified on this form.

Provider's printed name: ___

Provider's signature: ___

Date: ___



NAME:
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Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Barriers to learning

- Non-English speaking. Language: _____
- Psychosocial
- Hearing
- Vision
- Physical limitations
- None

Outpatient Ostomy Clinic Intake Team: PORTLAND (PPMC) Phone-503-215-6046 Fax-503-487-3582