



Healing Hands. Caring Hearts.™

Ostomy Management Program Wound Clinic

8198 Walnut Hill Ln,
Jackson Bldg, 1st floor, Clinic C
Dallas, TX. 75231

Phone 214-345-4334

FAX 214-345-4183

FAX

| | |
|----------------------------|-----------------------|
| To: <i>Angela</i> | From: |
| Fax: <i>(214) 987-1845</i> | Pages: |
| Phone: | Date: <i>11/20/18</i> |
| CC: | Re: |

Urgent

Review

Comment

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NOTES:

Your patient has requested Ostomy Education and Management. Please fill out the attached Physician order Form and Fax back with:

- Physician Order Form
- Insurance Information
- Patient Demographics (Face Sheet)
- History and Physical

MUST HAVE prior to scheduling an appointment, Mondays - Fridays 1pm - 2pm

Please fax this to 214-345-4183. If you have any questions or need assistance, call 214-345-4334.

Confidentiality Notice: The document accompanying the transaction contain confidential health information that is legally privileged. The information is intended ONLY for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing the information to any other party unless required to do so by the law or regulations.

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Texas Health

Presbyterian Hospital

Dallas

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Ostomy Education and Management Program Referral Form**Office # 214-345-4334****FAX # 214-345-4183**

| | |
|--------------------------------|---------------|
| Patient' Name (Last, First, M) | Date of Birth |
|--------------------------------|---------------|

***** Attach Patient's Demographics, insurance Information and H&P

| | | | |
|-------------------------------------|--------------------|-------------------|-----------|
| <u>Ostomy Type</u> | | | |
| Colostomy | Ileostomy | Urostomy | Others |
| <u>Patient's Limitations</u> | | | |
| Language | Hearing impairment | vision Impairment | Dexterity |

Education/Management Ordered

| OSTOMY | FISTULA | PERCUTANEOUS TUBE |
|--|---|---|
| <input type="checkbox"/> Pre-op teaching and counseling | <input type="checkbox"/> Establishment and modification of effective containment system | <input type="checkbox"/> Stabilization of newly placed tube |
| <input type="checkbox"/> Stoma site selection & Marking. | <input type="checkbox"/> Protection of Peri fistula skin | <input type="checkbox"/> Site Care and tube management |
| <input type="checkbox"/> Client, family education and counseling | | <input type="checkbox"/> Hypertrophic granulation tissue |
| <input type="checkbox"/> Individualized instruction of basic principle of care | | |
| <input type="checkbox"/> Routine follow up after hospital/agency discharge | | |
| <input type="checkbox"/> Other: | | |

As health care provider, I certify Ostomy Self- Management Training is needed to ensure therapy compliance, necessary skills and knowledge to enable this patient to manage his/her condition.

| | | |
|----------------|-----------|------|
| Physician Name | Signature | Date |
|----------------|-----------|------|