# TriStar Skyline MEDICAL CENTER

## WOUND AND OSTOMY CLINIC REFERRAL

Dr. Gregory Neal - Medical Director

Contacts: Deborah P Gray MSN, RN, CWOCN, CFCN
Linda D Fine MSN, RN, CWOCN, CFCN

Schedule Appointment: (615)769-7226, option 1
Fax this Referral Order to: 1-866-401-6442

Office Phone #: (615)769-2933

Referral Date: _____ Ostomy Surgery Date: _____

Referring Phys: _____ PCP: _____

Patient: _____ SS#: _____

Date of Birth: _____

Allergies: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Reason for Referral: _____

Services Requested: _____

Pt's Home Ph#: _____ Work/Cell Ph#: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Insurance: _____

ID #: _____ Group #: _____

Physician Signature/Date/Time: _____

Physician's Name (Printed): _____

Please fax signed copy to 1-866-401-6442. Include a copy of most recent H&P/Progress Note, recent labs, and x-rays as appropriate.

*POS*