



## United Ostomy Association, Inc.

### PATIENT REFERRAL FORM

Your healthcare team has recommended that you have the benefit of a person-to-person visit from a certified ostomy visitor. This is a free service of the United Ostomy Association. The visitor is well qualified to answer your questions and share tips on living with an ostomy.

**Confidentiality/Privacy Statement:** The identities of individuals that are referred to UOA are held in confidence and will not be released outside the organization.

#### Patient Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # (optional) \_\_\_\_\_ Email address (optional) \_\_\_\_\_

Type of Ostomy: \_\_\_\_\_  Temporary

Type of Continent Diversion:  J-Pouch  Continent Urostomy

Age Group:  Parents  Teen  18-30  30-50  50 plus

#### Release:

I hereby give my permission to release the above information to the local chapter Visiting Coordinator and request that a visitor contact me.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### Local Chapter Contact Information

UOA Chapter Name:

Visiting Coordinator:

Phone Number:

#### UNITED OSTOMY ASSOCIATION, INC.

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