Wound Care Specialists

Innovative Approach...Superior Results

Referral Form

Patient: ______________________________ **Date:** ______________
Last First MI

Address: ______________________________
City State Zip

Phone: ______________ **Cell:** ______________ ☐ **M** ☐ **F** **DOB:** ______________

Alternate Contact: ______________________________ Relation: ______________

Phone: ______________________________ Cell: ______________________________

Primary Insurance Name ______________________________ SSN: ______________

Policy # ______________________________ Group # ______________________________

Secondary Insurance Name ______________________________

Policy # ______________________________ Group # ______________________________

Home Health: ☐ yes ☐ no Agency Name: ______________ Phone: ______________

Hospice: ☐ yes ☐ no Agency Name: ______________ Phone: ______________

Nursing Home: ☐ yes ☐ no Facility Name: ______________ Phone: ______________

Skilled Bed: ☐ yes ☐ no Skilled Bed End Date: ______________________________

Dialysis: ☐ yes ☐ no If yes, what days? ______________ Facility Name: ______________

☐ **WOUND Care Dx or ICD-9 / Reason for Referral** ______________________________

Number of wounds? ______________ Location of wounds ______________________________

☐ **PATIENT CAN SIGN CONSENT** / ☐ **NOT ABLE TO SIGN CONSENT/REASON** ______________

Arrival Method: ☐ **AMBULATORY** ☐ **WHEELCHAIR** ☐ **STRETCHER**

Transfer Assistance Required: ☐ **NONE** ☐ **MINIMAL ASSIST** ☐ **FULL ASSIST**

Has patient seen a vascular surgeon? ☐ yes ☐ no If yes, which one? ______________

Any additional information: ______________________________

Please FAX to (888) 835-6946 or (504) 835-6946

Referral Source ______________________________ **Phone:** ______________
(Print)

Referral Source ☐ Physician ☐ Discharge Planner ☐ Nursing Home ☐ Home Health

☐ Nurse Practitioner ☐ Other: ______________________________

Name of Person Completing This Form ______________ **Phone:** ______________

Primary Care Physician ______________ **Phone:** ______________

Ordering Physician ______________ **Signature** ______________ **Phone:** ______________