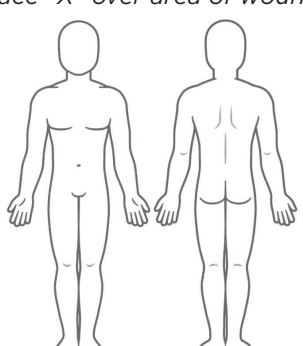


## WOUND CENTER REFERRAL FORM

Today's Date:		Patient DOB:	
Patient Name:		<input type="checkbox"/> M <input type="checkbox"/> F	
Primary Care Physician:		Phone:	
<b>PATIENT DEMOGRAPHICS</b> (may attach face sheet instead)			
Address:		City:	State: Zip:
Phone:		Alternate Phone:	
Is patient currently in an Assisted Living Facility (ALF)? <input type="checkbox"/> No <input type="checkbox"/> Yes			ALF Coordinator:
If yes, name of ALF:			Phone:
Address:		City:	State: Zip:
<b>PATIENT INSURANCE INFORMATION</b> (may attach face sheet instead)			
Primary:	Member ID#:	Phone:	
Secondary:	Member ID#:	Phone:	
TREATMENT WILL BE RENDERED AT: <input type="checkbox"/> Our Clinic <input type="checkbox"/> Patient's Home <input type="checkbox"/> ALF			
<b>REFERRAL REASON</b>		<i>Wound Location</i>	<i>Wound Size</i>
<input type="checkbox"/> Venous stasis	<input type="checkbox"/> Post thrombotic	<input type="checkbox"/> Diabetic Ulcer	Place "X" over area of wound: 
<input type="checkbox"/> Non-healing traumatic (e.g. resulting from a fall)	<input type="checkbox"/> Burn		
<input type="checkbox"/> Post surgical (include procedure if known)	<input type="checkbox"/> Pressure injury		
Has this wound been treated by healthcare professionals? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If so, for what period of time?	<input type="checkbox"/> < 30 days <input type="checkbox"/> 30-90 days <input type="checkbox"/> > 90 days		
<b>OTHER RELEVANT CONDITIONS</b> (check all that apply):			
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Venous Insufficiency <input type="checkbox"/> Malnutrition <input type="checkbox"/> Edema (including lymphedema) <input type="checkbox"/> Moderate to severe mobility restrictions <input type="checkbox"/> Arterial insufficiency <input type="checkbox"/> Suspected infection at the wound site			
<b>REFERRER INFORMATION</b>			
Name:		Phone:	Fax:
REFERRAL SOURCE: <input type="checkbox"/> Physician <input type="checkbox"/> Discharge Planner <input type="checkbox"/> Nursing Home			
<input type="checkbox"/> Home Health (HH) <input type="checkbox"/> Other:			
If no current HH, is there a preferred? <input type="checkbox"/> No <input type="checkbox"/> Yes		Phone:	Fax:
Case Nurse:		Phone:	Fax:
<b>OTHER PARTICIPATING CARE PARTNERS</b>			
Skilled Nursing:		Phone:	
Discharge Coordinator:		Phone:	

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.

CONFIDENTIAL NOTICE: This facsimile, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or information that is otherwise protected by law. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original facsimile.