



WOUND CARE REFERRAL REQUEST FORM

Please complete the following & return with required records for Medical Review via Fax 1-800-983-7668.
Thank You For Your Referral!

Patient Name

Full Name

Date of Birth

Month Day Year

Phone Number (Home)

Phone Number (Cell)

Insurance Provider

Address

Street Address

City

State / Province

Postal / Zip Code

Fax Number

Phone Number

Reason for Referral/Visit:

Does this Patient have any of the following:

☐

Chronic Wound
Greater than 30 Days

☐

Venous/Arterial
Insufficiency

☐

Diabetes

Required Records Please Provide The Following:

☐ Facesheet with FULL Demographics

☐ Current Visit Note

☐ Current Wound Photos

☐ Most Recent Lab Work - HgA1c/CMP/BMP/Wound Cultures
(If Applicable)

☐ Most Recent Diagnostic Imaging Results - ABIs/X-Rays of site
(If Applicable)

☐ Home Health 485
(If Applicable)

☐ Home Health Wound Records
(If Applicable)

☐ Home Health Discharge Records
(If Applicable)