

# Wound Care New Patient Referral Form



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ReviveCommunityHealth.Org

## Patient Information

Patient Name: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Patient Phone: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

Is patient diabetic? \_\_\_ Does patient have a pacemaker? \_\_\_ Does patient have home health? \_\_\_

Is patient ambulatory? \_\_\_ Does patient use a wheelchair or walker? \_\_\_

## Indications for Wound Care

- |   |   |
|---|---|
| <input type="checkbox"/> Ischemic ulcer | <input type="checkbox"/> Non-healing surgical wound |
| <input type="checkbox"/> Pressure ulcer | <input type="checkbox"/> Traumatic wound            |
| <input type="checkbox"/> Diabetic ulcer | <input type="checkbox"/> Wound flap                 |
| <input type="checkbox"/> Venous ulcer   | <input type="checkbox"/> Other ( _____ )            |

## Indications for HBO

- |   |  |
|---|--|
| <input type="checkbox"/> Acute sensory hearing loss       | <input type="checkbox"/> Acute retinal artery occlusion        |
| <input type="checkbox"/> Chronic refractory osteomyelitis | <input type="checkbox"/> Diabetic ulcer of the lower extremity |
| <input type="checkbox"/> Osteoradionecrosis               | <input type="checkbox"/> Compromised skin graft                |
| <input type="checkbox"/> Soft tissue radionecrosis        |  |

Diagnosis: \_\_\_\_\_

Wound Location: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Please send with patient or fax a list of medications, recent labs and x-ray, H&P and progress notes.*

Referring Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician Signature \_\_\_\_\_ NPI \_\_\_\_\_