



WOUND CARE REFERRAL

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ ☐ Male ☐ Female
Phone: _____
Insurance: _____

Member ID: _____
Additional Information (if needed):

REASON FOR REFERRAL (Select all that apply)

- | | | |
|--|--|--|
| ☐ Nonhealing wound | ☐ Post-vascular procedure wound | ☐ Wound infection / recurrent |
| ☐ Venous ulcer | ☐ Post-surgical wound | ☐ Delayed healing |
| ☐ Arterial / ischemic wound | ☐ Pressure injury | ☐ Second opinion |
| ☐ Diabetic foot ulcer | ☐ Lymphedema with ulceration | ☐ Other: _____ |

WOUND LOCATION AND CLINICAL INFORMATION

Location(s) of wound: _____

Brief clinical summary / specific concerns: _____

VASCULAR CARE INFORMATION (if applicable)

- ☐ Recent vascular procedure (date): _____
☐ Planned vascular procedure
☐ Under vascular evaluation
☐ No recent vascular intervention

Vascular studies available (please send if applicable)

- ☐ ABI / TBI ☐ Operative report
☐ Arterial / venous studies ☐ Other: _____

REFERRING PROVIDER / PRACTICE

Provider Name: _____
Practice Name: _____
Phone: _____

Fax: _____
Email (optional): _____
Preferred method of communication: ☐ Phone ☐ Fax ☐ Email

RECORDS INCLUDED WITH FAX

- | | |
|--|--|
| ☐ Completed referral form | ☐ Current treatment orders |
| ☐ Recent visit notes | ☐ Medication / allergy list |
| ☐ Recent testing | ☐ Other: _____ |

PLEASE FAX COMPLETED REFERRAL FORM
AND AVAILABLE RECORDS TO

810-202-7988

Thank you for your collaboration.