Wound Care Referral Form

Advanced Wound Care Services — Physician-Led Assessment & Treatment

REFERRING PROVIDER / FACILITY

Provider Name: _____ **NPI:** _____

Facility Name: _____ **Phone:** _____

Contact Person: _____ **Fax:** _____

PATIENT INFORMATION

Patient Full Name: _____ **Date of Birth:** _____

Address / Facility Room #: _____

Phone: _____ **Insurance / Member ID:** _____

WOUND INFORMATION

Wound Type (check all that apply):

■ Chronic Non-Healing Wound

■ Diabetic Foot Ulcer

■ Pressure Injury / Decubitus Ulcer (Stage: _____)

■ Post-Surgical Wound

■ Venous Ulcer

■ Arterial Ulcer

■ Skin Graft / Debridement Follow-Up

■ Other: _____

Wound Location (anatomical site): _____

Approximate Size (L x W x D): _____ **Duration of Wound:** _____

Current Treatment / Dressings: _____

Signs of Infection?

■ Yes — describe: _____

■ No

PERTINENT MEDICAL HISTORY

■ Diabetes (Type: ___ HbA1c: _____)

■ Peripheral Vascular Disease

■ Venous Insufficiency

■ Immunocompromised

■ On Anticoagulants

■ Other: _____

ADDITIONAL CLINICAL NOTES

_____
_____
_____

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

Fax completed form to: 210-251-4912 | **Call:** 210-251-4911 | **Email:** contact@primevitalityhealth.com