



Referral Request

Urgent Routine

PATIENT INFO:

Patient Name: _____

Date of Birth: ____/____/____

Patient Address: _____

Preferred Phone #: _____

Insurance Carrier: _____

ID #: _____ Group #: _____

SPECIAL NEEDS:

- Hearing Impaired
- Vision Impaired
- Home Health
 - Infectious Disease
 - Wound Care
- Language Limitations

- Physical Limitations

- Other

MARK ALL THAT APPLY:

- | | |
|--|---|
| <input type="checkbox"/> Active Infection | <input type="checkbox"/> Surgical site infections |
| <input type="checkbox"/> Recurrent Infection | <input type="checkbox"/> Surgical wound dehiscence |
| <input type="checkbox"/> Chronic & nonhealing wounds | <input type="checkbox"/> Hematoma incision/drainage |
| <input type="checkbox"/> Diabetic foot ulcers | <input type="checkbox"/> Punch biopsies |
| <input type="checkbox"/> Venous insufficiency ulcers | <input type="checkbox"/> Wound debridement |
| <input type="checkbox"/> Venous stasis dermatitis | <input type="checkbox"/> Multi-layer compressions |
| <input type="checkbox"/> Furuncles/Carbuncles | <input type="checkbox"/> Recently Hospitalized |
| <input type="checkbox"/> Abscesses | Location: _____ |
| <input type="checkbox"/> Arterial Ulcers | Provider Name: _____ |

TYPE OF REFERRAL:

- Evaluate & Treat
- Consult Only

REQUIRED INFORMATION:

- | | |
|--|---|
| <input type="checkbox"/> Patient Demographics | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> Insurance Card(s) | <input type="checkbox"/> Most Recent Labs |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Wound Cultures |
| <input type="checkbox"/> Therapy Order | <input type="checkbox"/> Diagnostic Imaging |
| <input type="checkbox"/> Currently Receiving Home Health | |

REFERRING PHYSICIAN/NP/PA:

Name: _____ Phone: (____)____-____ Fax: (____)____-____

Date: _____

Has patient been seen by a vascular, wound, or another infectious disease specialist? If so, who? _____

Please fax referral to (901) 685-3499