NIVA HEALTH
WOUND CARE

Phone: (704) 992-7778
Fax 1-704-703-5595

ANDREW@NIVAHEALTH.COM - NIVAHEALTHWOUNDCARE.COM

WOUND CARE REFERRAL REQUEST FORM

Please complete the following & return with required records for Medical Review via Fax 1-704-703-5595 . 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 then 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)