NIVA HEALTH
WOUND CARE FLORIDA

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WOUND CARE REFERRAL REQUEST FORM

Please complete the following & return with required records for Medical Review via Fax 1-817-768-5097.
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)