



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 than 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)