

Tucson
Tel: 520-603-8043
Fax: 520-257-4320

Phoenix
Tel: 520-399-5671
Fax: 480-900-8472



Center Name and Contact Information:

FAX:

PHONE:

Today's Date:

Patient Name:

Primary Care Physician:

Patient DOB:

☐ M ☐ F

Phone:

PATIENT DEMOGRAPHICS (may attach face sheet instead)

Address:

City:

State:

Zip:

Phone:

Alternate Phone:

PATIENT INSURANCE INFORMATION (may attach face sheet instead)

Primary:

ID#:

Group#:

Phone:

Secondary:

ID#:

Group#:

Phone:

Is patient in a nursing home?

☐ No ☐ Yes

Facility name:

Is patient a SNF resident?

☐ No ☐ Yes

Facility name:

Is patient receiving home health care?

☐ No ☐ Yes

Facility name:

Auto or workman's compensation claim

☐ No ☐ Yes

Is patient in the hospital? ☐ No ☐ Yes

Room No.

Is this a swing bed? ☐ No ☐ Yes

REFERRAL REASON

Wound Location

Wound Location

☐ Arterial/ischemic ulcer

☐ Compromised skin graft or flap

☐ Diabetic foot ulcer

☐ Crush injury

☐ Pressure injuries/ulcer

☐ Non-healing, post-surgical wound

☐ Venous ulcer

☐ Traumatic wound

☐ Post-radiation ulcer/wound

☐ Other

ADDITIONAL COMMENTS OR WOUND DISCRPTIONS AND MEASUREMENTS:

Is patient on antibiotics?

☐ No ☐ Yes

RX name:

Is patient on blood thinners?

☐ No ☐ Yes

RX name:

REFERRER INFORMATION

Name:

Phone:

Fax:

Referral Source:

☐ Physician

☐ Discharge Planner

☐ Nursing Home

☐ Nurse Practitioner

☐ Home Health

☐ PA

☐ Other:

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.

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