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

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

OLD PUEBLO
SPECIALTY GROUP

Center Name and Contact Information:

FAX: **PHONE:**

Today's Date:

Patient Name:

Primary Care Physician:	Patient DOB: 05/20/2025
	☐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 DISCRIPTIONS 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.