IT'S HAPPENING HERE

WOUND HEALING CENTER

Fax Referral Form

Date ______________________________

PATIENT INFORMATION

Name ______________________________

Date of Birth ______________________________

Phone ______________________________

Address ______________________________

____

PRIMARY CARE PROVIDER

Name ______________________________

REFFERING PROVIDER

Name ______________________________

Phone ______________________________

Fax ______________________________

INSURANCE

ICD-10 Code ______________________________

Primary ______________________________

Secondary ______________________________

WOUND INFORMATION

Wounding Event ______________________________

Etiology of the Wound ______________________________

- ☐ Left Leg
- ☐ Right Leg
- ☐ Left Foot
- ☐ Right Foot
- ☐ Coccyx/Sacrum
- ☐ Other (specify) ______________________________

____

Special Needs? DPOA? ______________________________

Legal Guardian ______________________________

Is patient amulatory or do they require transport?

- ☐ Ambulatory
- ☐ Transport Requires
  - ☐ Stretcher
  - ☐ Wheelchair

FOR OFFICE USE ONLY

Appointment Date ______________________________

Appointment Time ______________________________

PLEASE SEND a copy of patient's **History and Physical**, a recent **Progress Note**, most recent **Labs**, **Vascular Studies**, **X-ray/imaging**, current **Problem and Medication List**, and a current **Face Sheet** when faxing referral. Thank you.

10/20

Metro Health Wound Healing Center

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METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH
Wound Healing Center