NEWCARE WOUND SOLUTIONS

Patient Referral Form

Fax to (424) 438-2585

Phone (424) 509-0878 · Info@NewCareWoundSolutions.com · Referrals accepted 24/7 · Patients seen within 48 hours

1. REFERRAL SOURCE

REFERRAL DATE | FACILITY / AGENCY / PRACTICE | CONTACT NAME

PHONE | FAX | EMAIL

2. PATIENT

PATIENT NAME (LAST, FIRST) | DATE OF BIRTH | PATIENT PHONE

ADDRESS | CITY | ZIP

PREFERRED LANGUAGE | CAREGIVER / EMERGENCY CONTACT | CAREGIVER PHONE

3. CARE SETTING

- ☐ Private home
- ☐ Assisted living
- ☐ Board and care
- ☐ Skilled nursing facility
- ☐ Home health patient
- ☐ Hospice

FACILITY OR AGENCY NAME / ROOM

4. INSURANCE

PRIMARY INSURANCE | MEMBER ID | SECONDARY INSURANCE | MEMBER ID

5. WOUND INFORMATION

WOUND TYPE AND LOCATION | HOW LONG PRESENT | APPROX. SIZE

CURRENT TREATMENT / DRESSING | ALLERGIES

- ☐ Diabetes
- ☐ Poor circulation / PAD
- ☐ Signs of infection
- ☐ Limited mobility
- ☐ On anticoagulants

RELEVANT DIAGNOSES / CLINICAL NOTES

6. SERVICES REQUESTED

- ☐ Wound assessment
- ☐ Advanced dressings
- ☐ Compression therapy
- ☐ Infection management
- ☐ Patient / caregiver education
- ☐ Debridement
- ☐ Wound vac (NPWT)
- ☐ Advanced therapy evaluation
- ☐ G-tube care

7. DOCUMENTS ATTACHED

- ☐ Face sheet
- ☐ Medication list
- ☐ Physician order
- ☐ H&P / recent clinical notes
- ☐ Insurance card(s)
- ☐ Wound photos

OTHER / NOTES

8. ORDERING PHYSICIAN

PHYSICIAN NAME | NPI | PHONE | FAX

DATE

PHYSICIAN SIGNATURE

CONFIDENTIAL: This fax contains protected health information. If you received it in error, please notify the sender at (424) 509-0878 and destroy all copies. In a medical emergency, call 911.