

Referral Form

Transforming Lives by Providing Advanced Wound Solutions Wherever You Call Home



Referring Provider/Agency: _____ Fax: ____-____-____

Patient Name: _____ DOB: ____/____/____

Patient Phone: ____-____-____ Patient Sex: ☐ M / ☐ F Patient Location: ☐ Home ☐ Facility

If facility, what's the facility name? _____

Patient Location Address: _____ City: _____ State: ____ Zip: ____

Primary Care Physician Name: _____ Fax: ____-____-____

POA/Caregiver Involved: Y / N If yes, name & contact: _____

Emergency Contact (if different from above): _____

Wound Location: _____ Approximate Size: ____ cm x ____ cm x ____ cm

Onset Date of Wound (best approximation): ____/____/____ Wound Diagnosis: _____

Previous Treatments: _____

Primary Insurance: ☐ Medicare ☐ Medicare Advantage ☐ Commercial ☐ VA ☐ Other _____

Preferred Pharmacy Name, Location and Phone: _____

Other Notes: _____

Home Health Agency (if different from referral source): _____

Home Health Case Manager: _____

Phone: ____-____-____ Email: _____

Home Health Treating RN: _____

Phone: ____-____-____ Email: _____

Please be sure to also include the following:

- ☐ Facesheet with insurance information
- ☐ Records of prior treatment of current wounds
- ☐ Medication list
- ☐ Photos of the wounds, if possible

Next Steps:

- 1. Fax referral to 864-519-2711.**
- 2. Email us to confirm it's been received.**
- 3. We will fax you notes/orders ASAP.**