- University of Kentucky Hospital A.B. Chandler Medical Center
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Heatlh Clinics

COMPREHENSIVE VASCULAR CLINIC
NEW PATIENT REFERRAL FORM

(Patient Label Here)

Comprehensive Vascular Clinic
740 S. Limestone
Phone: 859-218-6388
Fax: 859-323-7755

Patient must have an open wound to be appropriate for referral.

Medical Record #: ____________________

Patient Name: ______________________________ SS#: ____________________

Address: ______________________ City: ______________ State: ______ Zip: ______

DOB: __________ Age: ______ Sex: __________ Phone: ____________________

Primary Insurance: ______________________________ ID#: ____________________

Secondary Insurance: ______________________________ ID#: ____________________

	Yes	No
Is patient diabetic?	☐	☐
Is patient oriented?	☐	☐
Is patient ambulatory?	☐	☐
Is patient being brought by EMS?	☐	☐
Is patient from facility?	☐	☐

Does patient have home health? ____________________

If yes, Name & Phone of Home Health

____
Name of Home Health Agency/Provider

____
Home Health Phone Number

If yes, Name and Phone of Facility ______________________________ ____________________

Home Health Phone Number / Facility Phone Number

Does patient use: ☐ Wheelchair ☐ Walker ☐ Stretcher

Interpreter needed? ☐ Yes ☐ No

How does the patient transfer? ______________________________

Diagnosis: ☐ Pressure Ulcer ☐ Ischemic Wound ☐ Surgical Wound ☐ Traumatic Wound
☐ Diabetic Ulcer ☐ Wound Flap ☐ Venous ☐ Burn
☐ Other: ______________________________

Location / Comments: ______________________________

____

Referring Provider: ______________________________ ______________________________
(Provider Name) (Provider Phone Number)

______________________________ ______________________________
Referring Provider's Signature: Date / Time:

Contact: ______________________________ Phone: ______________________________