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HealthCare

UK GOOD SAMARITAN
WOUND CARE CLINIC
NEW PATIENT REFERRAL FORM

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

_____
(home health name)

_____
(home health Phone number)

If yes, Name and phone of facility _____ _____
(facility name) (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 (please comment below)

Location/Comments: _____
_____

Referring Provider: _____ _____
(provider name) (physican phone)

Referring Provider's Signature_____

Contact:_____ Phone: _____