CCMC Health System

WOUND CARE

Fax this form and requested information to: 254-879-3289

Date of Referral: _____

Patient Information

Patient Name:_____ DOB:__/__/___ Age:____ Sex:____

Patient Phone:_____ City:_____ State:_____ Zip:____

Primary Insurance:_____ Policy #:_____

Secondary Insurance:_____ Policy #: _____

Is patient diabetic?_____ Is patient ambulatory?_____ Does patient use a wheelchair or walker? _____

Does patient have a pacemaker?_____ Does patient have home health?_____

Indications for Wound Care

- ☐ Ischemic Ulcer
- ☐ Pressure Ulcer
- ☐ Diabetic Ulcer
- ☐ Venous Ulcer
- ☐ Non-healing surgical wound
- ☐ Traumatic wound
- ☐ Wound Flap
- ☐ Other (_____)

☐ STAT ☐ Routine ☐ Call for Same Day Appointment

Diagnosis: _____

Wound Location: _____

Comments:_____

_____ _____

Referring Physician Name (please print): Phone # and Office contact name

_____ _____

Referring Physician Signature: Referring Provider NPI #

Please send facesheet, copy of insurance cards, list of medications, recent labs, x-rays, H&P and progress notes.