**Optimum Wound Care**

**REFERRAL FORM**

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| --- | --- | --- |
| Today’s Date: | * Urgent | * Non-urgent |
| Primary Care Physician: | Phone: | |
| Referring Physician/Facility: | Phone: | |
| PATIENT DEMOGRAPHICS (may attach face sheet instead) | | |
| Patient Name: | * M * F | DOB: |
| Address: | City: State: Zip: | |
| Phone: | Alternate Phone: | |
| PATIENT INSURANCE INFORMATION: | | |
| Wound Location: | | |
| Type of Wound | | |
| * Arterial/ischemic ulcer | * Compromised skin graft or flap | |
| * Diabetic foot ulcer | * Crush injury | |
| * Pressure injuries/ulcer | * Non-healing, post-surgical wound | |
| * Venous ulcer | * Traumatic wound | |
| * Post-radiation ulcer/wound | * Stoma (urostomy /ileostomy/colostomy) | |
| * Other | * Unknown | |
| Past Medical/ Surgical History: | | |
| Is patient on antibiotics?   * No * Yes | RX name: | |
| Is patient on anticoagulant?   * Yes * No | RX name: | |
| REFERRER INFORMATION |  | |
| Name: | Phone: Fax: | |
| Additional comments: | | |

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