Pro Healthcare Medical Group
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New Wound Care Patient Referral Form

Patient Name: _____ SS#: _____ Address: _____
City:_____
State: _____ Zip: _____ DOB: _____Age:___Sex:___ Race_____ Phone: _____
Primary Insurance_____ Number_____
Secondary Insurance _____ Number_____

Check that all apply

_____ *Patient is diabetic*

_____ *Patient has a pacemaker*

_____ *Patient has home health*

_____ *Patient is ambulatory*

_____ *Patient uses a wheelchair or walker*

Diagnosis:
_____ *Pressure Ulcer*
_____ *Ischemic Wound*
_____ *Surgical Wound*
_____ *Diabetic Ulcer*
_____ *Traumatic Wound*
_____ *Wound Flap*
_____ *Venous Ulcer*
_____ *Other (_____)*

Diagnosis/Wound Location/Comments:
_____
_____
_____

Please send with patient or fax: a list of all medications, any recent labs, H&P, and progress notes.

Are you a referring provider_____
Your Name_____
Phone # _____
Date_____ Signature_____

Are you a referring agency _____
Agency Name_____
Phone # _____
Date_____ Signature_____