VITAL WOUND .Care

REFERRAL FORM

Please provide the following information. We look forward to treating your patient.

PATIENT INFORMATION		**TODAY'S DATE: / /2024**	
LAST NAME:	FIRST NAME:	GENDER: ☐ M ☐ F	PATIENT DOB:
ADDRESS:		PHONE:	
ALTERNATE CONTACT:	RELATIONSHIP:	PHONE:	

INSURANCE INFORMATION (may attach face sheet)		
PRIMARY:	ID#:	GROUP#:
SECONDARY:	ID#:	GROUP#:

PRIMARY PHYSICAN:	CONTACT #:
DOES PATIENT HAVE HOME HEALTH SERVICES? ☐ NO ☐ YES IF YES, AGENCY:	
PREFERRED HOME HEALTH AGENCY?:	

WOUND INFORMATION (add notes and/or anatomical side when applicable)	**ONSET DATE:**
☐ Diabetic Foot Ulcer ☐ Venous Ulcer ☐ Arterial/Ischemic Ulcer ☐ Post-Surgical ☐ Infectious ☐ Pressure Injury/Ulcer, Stage: ☐I ☐II ☐III ☐IV ☐__ ☐ Traumatic Injury ☐ Post-Radiation Injury ☐ Other: _____	
IS PATIENT ON ANTIBIOTICS? ☐ YES ☐ NO RX:	IS PATIENT ON BLOOD THINNERS? ☐ YES ☐ NO RX:
DIAGNOSIS and ICD-10 CODES:	
PREVIOUS TREATMENT (include length of treatment):	

REFERRAL SOURCE						
☐ Physician	☐ Skilled Nursing	☐ Home Health	☐ Discharge Planner	☐ NP	☐ PA	☐ Other
REFERRING SOURCE NAME:						
REFFERING OFFICE CONTACT:			PHONE:		FAX:	

PROVIDER SIGNATURE: _____ DATE: _____

Fax to **(833)-463-4753** or encrypted email to referrals@vitalwound.care with all pertinent imaging/lab results, patient history, and progress notes