



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: <input type="checkbox"/> M <input type="checkbox"/> F	PATIENT DOB:
ADDRESS:		PHONE:	
ALTERNATE CONTACT:	RELATIONSHIP:	PHONE:	

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

PRIMARY PHYSICIAN:	CONTACT #:
DOES PATIENT HAVE HOME HEALTH SERVICES? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, AGENCY:	
PREFERRED HOME HEALTH AGENCY?:	

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

REFERRAL SOURCE		
<input type="checkbox"/> Physician <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Home Health <input type="checkbox"/> Discharge Planner <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other		
REFERRING SOURCE NAME:		
REFERRING 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

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