

SPECIALTY WOUND CARE REFERRAL FORM



PATIENT INFORMATION

Name _____ DOB _____

Phone _____ Address _____

City _____ State _____ Zip _____

Primary Care Provider _____

Home Health Agency _____

Where will the wound care take place? Patient's Home Skilled Nursing Facility
 Other _____

INSURANCE

Primary Insurance _____ Member ID / Policy # _____

Secondary Insurance _____ Member ID / Policy # _____

WOUND INFORMATION

New Wound: Yes No Previous Wound Care: Yes No

Current/previous provider treating wound _____

Wound Size _____ Wound Location _____

Wound Duration _____

Fax or Email to (509) 381-3540 or woundcare@upwellventures.com along with:

- Health insurance card(s)
- Demographics sheet
- Recent & past wound photos in color showing size of wound
- All chart notes pertaining to wound care

REFERRING COMPANY

Care Coordinator Name _____ Date _____

Email _____ Phone _____ Fax _____