# SPECIALTY WOUND CARE REFERRAL FORM

ELEVATE WOUND CARE

## PATIENT INFORMATION

Name _____ DOB _____

Phone _____ Address _____

City _____ State _____ Zip _____

Primary Care Provider _____

Home Health Agency _____

## 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** form to **(983)-210-0350** or **woundcare@upwellventures.com**

- ☐ Health Insurance Card(s)
- ☐ Demographics Sheet
- ☐ Most recent wound photo(s) in color showing size of wound
- ☐ All chart notes pertaining to wound care
- ☐ Past pictures of wound (if available)

## REFERRING COMPANY

Care Coordinator Name _____ Date _____

Email_____ Phone_____ Fax_____

**woundcare@upwellventures.com**
**Call or Fax: (983)-210-0350**