# SPECIALTY WOUND CARE REFERRAL FORM

CLINIC 5C
WELCOME TO THE NEXT LEVEL

## 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@clinic5c.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 _____