SPECIALTY WOUND CARE REFERRAL FORM

VANTAGE 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 **(516) 899-8901** 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 _____