CONFIDENTIAL FAX

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Premier Wound Care — Referral Form (I-Page)
Phone: (860) 891-6859
Fax: (860) 891-1311 | (860) 467-7601

PATIENT INFORMATION

Name _____ D.O.B: ____ | ____ | _____

Phone: _____ Address _____

Insurance: _____ ID: _____

REFERRING PROVIDER

Provider Name: _____

Facility: _____

Phone: _____ Fax: _____

REFERRAL (Check all that apply)

- ☐ Non-healing wound
- ☐ Diabetic ulcer
- ☐ Pressure injury
- ☐ Vernous ulcer
- ☐ Arterial Ulcer
- ☐ Surgical wound
- ☐ Surgical wound
- ☐ infection suspected
- ☐ Other: _____

Urgency: ☐ Routine ☐ Urgent (Less than or equal 48 hours requested)

WOUND DETAILS (Minimum Required)

Location: _____

Duration: _____

Signs of Infection: ☐ No ☐ Yes → ☐ Redness ☐ Drainage ☐ Odor ☐ Fever

KEY HISTORY (Check if present)

- ☐ Diabeties
- ☐ PAD / Vascular disease
- ☐ Venous insufficiency
- ☐ Neuropathy
- ☐ Immobility
- ☐ Smoking

CURRENT CARE

Treatment: _____

CURRENT LOCATION

☐ Home ☐ Assisted Living SNF

Facility (If applicable) _____

Contact: _____ Phone _____

ATTACH (if available)

- ☐ Medication list
- ☐ Labs / imaging
- ☐ Vascular studies
- ☐ Wound Photos

AUTHORIZATION

Provider Signature: _____ Date: ____ | ____ | ____