**NEMAHA VALLEY**
Community Hospital & Seneca Family Practice

CENTER NAME AND CONTACT INFORMATION:

**Wound Care Clinic**
**Phone: 785-336-0355**
**Fax: 888-835-6946**

# WOUND CENTER REFERRAL FORM

| | | | |
|---|---|---|---|
| Today's Date: | | Patient DOB: | |
| Patient Name: | | ☐M ☐F | |
| Primary Care Physician: | | Phone: | |

**PATIENT DEMOGRAPHICS** *(may attach face sheet instead)*

| | | | |
|---|---|---|---|
| Address: | City: | State: | Zip: |
| Phone: | Alternate Phone: | | |

**PATIENT INSURANCE INFORMATION** *(may attach face sheet instead)*

| | | |
|---|---|---|
| Primary: | ID#: | Group#: |
| Phone: | | |
| Secondary: | ID#: | Group#: |
| Phone: | | |

| | | | |
|---|---|---|---|
| Is patient in a nursing home? | ☐No ☐Yes | Facility name: | |
| Is patient a SNF resident? | ☐No ☐Yes | Facility name: | |
| Is patient receiving home health care? | ☐No ☐Yes | Facility name: | |
| Auto or workers' compensation claim? | ☐No ☐Yes | | |
| Is patient in the hospital? | ☐No ☐Yes | Room No. | Is this a swing bed? ☐No ☐Yes |

| **REFERRAL REASON** | ***Wound Location*** | | ***Wound Location*** |
|---|---|---|---|
| ☐Arterial/ischemic ulcer | | ☐Compromised skin graft or flap | |
| ☐Diabetic foot ulcer | | ☐Crush injury | |
| ☐Pressure injuries/ulcer | | ☐Non-healing, post-surgical wound | |
| ☐Venous ulcer | | ☐Traumatic wound | |
| ☐Post-radiation ulcer/wound | | ☐Other | |

ADDITIONAL COMMENTS:

| | | |
|---|---|---|
| Is patient on antibiotics? | ☐No ☐Yes | RX name: |
| Is patient on blood thinners? | ☐No ☐Yes | RX name: |

**REFERRER INFORMATION**

| | | | | |
|---|---|---|---|---|
| Referral Source: | ☐Physician | ☐Discharge Planner | ☐Nursing Home | ☐Nurse Practitioner |
| | ☐Home Health | ☐PA | ☐Other: | |

| | | |
|---|---|---|
| Referrer Name: | Phone: | Fax: |
| Referral Office Contact: | Phone: | Ext: |

**PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.**

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