HAYWOOD
WOUND CARE

Phone: 828.452.8594 | Fax: 828.452.8775
7th Floor | 262 Leroy George Drive
Clyde, NC 28721

FAX REFERRAL FORM

Date: _____

Patient: _____

How did patient hear of clinic?
_____

Primary Physician: _____

Specialty: _____

Phone Number: _____

Fax Number: _____

Referral Number: _____

Primary Insurance: _____

Secondary Insurance: _____

Patient Address: _____
_____
_____

Phone number to reach patient to schedule appointment: _____

Patient's Weight: _____

Patient' Height: _____

Does the patient have an open wound?
□ Yes ■ No

Wound #1	#2	
□	□	Right Leg
□	□	Left Leg
□	□	Right Foot
□	□	Left Foot
□	□	Coccyx/Sacrum
□	□	Other (specify)

_____

Transportation Needed? _____

Is patient ambulatory or do they require transport?
□ Ambulatory
□ Transport requires
____ Stretcher
____ Wheelchair

Please send when faxing referral:
- □ patient's **History and Physical**
- □ recent **Progress Note**
- □ most recent **Labs**,
- □ **Vascular Studies**
- □ **X-ray/imaging**
- □ current **Problem and Medication List**
- □ current **Face Sheet**

FOR OFFICE USE ONLY:

Appointment Date: _____

Appointment Time: _____

Confirmation Call Made: _____

Transportation Scheduled: _____

Thank You