

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's Weight: _____

Patient: _____

Patient' Height: _____

How did patient hear of clinic?

Does the patient have an open wound?
 Yes No

Primary Physician: _____

Wound #1	#2	
<input type="checkbox"/>	<input type="checkbox"/>	Right Leg
<input type="checkbox"/>	<input type="checkbox"/>	Left Leg
<input type="checkbox"/>	<input type="checkbox"/>	Right Foot
<input type="checkbox"/>	<input type="checkbox"/>	Left Foot
<input type="checkbox"/>	<input type="checkbox"/>	Coccyx/Sacrum
<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)

Specialty: _____

Phone Number: _____

Fax Number: _____

Referral Number: _____

Transportation Needed? _____

Primary Insurance: _____

Is patient ambulatory or do they require transport?

Secondary Insurance: _____

- Ambulatory
 Transport requires

Patient Address: _____

_____ Stretcher
_____ Wheelchair

Phone number to reach patient to schedule appointment: _____

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