REFERRAL FORM

HEALING HANDS WOUND CARE CENTER

1109 Pamela Drive Ste. B, Mission, TX 78572

Office: (956) 271-4364 Fax: (956) 545 - 0570

DATE: ______________________________

APPOINTMENT TYPE: ___STAT ___1ST AVAILABLE

___Arterial Ulcer ___Burn/Post Radiation ___ Diabetic Foot Ulcer ___Infectious Wound

___Pressure Injury/Ulcer (Stage I II III IV) ___ Venous Leg Ulcer

___Notes/Other ____

AGE OF WOUND (if known) ___New ___Less than 30 days ___Over 30-days

LOCATION OF WOUND ___Lower Extremity LEFT ___Lower Extremity RIGHT ___Trunk

___Upper Extremity LEFT ___Upper Extremity RIGHT

INSURANCE INFORMATION (circle all that apply) **Medicare Part B** **Tri-Care** **VA** **Aetna** **BCBS** **Cigna** **Humana** **Medicare** **Molina** **UHC** **Other** ____

PATIENT INFORMATION:

Patient's Name: ____ ___M ___F DOB:___________

Address: ____City: _______ St: ___________ Zip: ________

Patient Daytime Phone #: ____________________________ Evening Phone #: ________________________

Care Taker Name: ______________________________ Relation to Patient: __________________________

Care Taker Phone #: ____

Reason for Consultation: ____

Diagnosis and ICD-20 Codes ____

Please fax the below or any pertinent information with this form to our
HIPPA Compliant FAX #: *(956) 545 - 0570*

- **Patient's demographics/insurance/updated history and physician report**
- **Lab Reports**
- **Pictures of Wound (if available)**
- **Patients Last 30-days Progress Notes**

One of our Patient Care Team members will contact patient directly to schedule the appointment.

PROVIDERS SIGNATURE: ____ DATE: ____________________

PROVIDE PHONE: ____ FAX: ___________________________

OFFICE USE ONLY: ______ Unable to contact patient

Patient Appointment Scheduled on ____________________________________at ______________am/pm

Notes: ____