Woundtech

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PATIENT REFERRAL FORM

ATTENTION: CASE MANAGERS, DISCHARGE PLANNERS, REFERRAL COORDINATORS AND UTILIZATION MANAGERS

ALL ITEMS MARKED WITH (*) ARE REQUIRED.

REFERRING PROVIDER INFORMATION*

PERSON COMPLETING THIS FORM: NAME: ______________________ PHONE#: ______________________

PATIENT AWARE OF REFERRAL TO WOUNDTECH? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: ______________________ PHONE #: ______________ FAX #: ______________

REFERRING PHYSICIAN (IF OTHER THAN PRIMARY): ______________________

REFERRING FACILITY NAME: ______________________

REFERRING FACILITY PHONE #: ______________ REFERRING FACILITY E-MAIL ADDRESS: ______________

IPA/MSO (IF APPLICABLE): ______________________

PATIENT INFORMATION

IS THE PATIENT'S PCP AWARE THAT WOUNDTECH WILL BE CONTACTING THE PATIENT FOR TREATMENT? ☐ YES ☐ NO

PATIENT NAME: ______________________ D.O.B.: ______________

PATIENT ADDRESS*: ______________________ CITY: ______________ STATE: ______ ZIP: ______

PATIENT PHONE*: ______________________ PATIENT EMAIL: ______________________

CAREGIVER/FAMILY PHONE*: ______________ CAREGIVER/FAMILY EMAIL*: ______________________

CURRENT LOCATION OF PATIENT: ______________________

PATIENT LOCATION: ☐ SNF/ALF ☐ HOME NUMBER OF VISITS*: ☐ 2 ☐ 8 ☐ 12

PATIENT SKILLED AUTHORIZATION # (IF PART A): ______________________

ELIGIBLE INSURANCE INFORMATION*

DATE OF REFERRAL: ______________ AUTHORIZATION NUMBER*: ______________________

NAME OF HEALTH PLAN: ______________________ PLAN TYPE: ______________________

MEMBER ID: ______________________

REASON FOR REFERRAL

CPT CODE*: ______________________ WOUND LOCATION: ______________________

WOUND TYPE: ☐ ARTERIAL ☐ DIABETIC ☐ PRESSURE ☐ SURGICAL ☐ TRAUMA ☐ VENOUS

☐ OTHER: ______________________

REFERRALS FROM PCP: include patient facesheet/demographics and pertinent medical records

REFERRALS FROM SNF: include patient facesheet/demographics, patient skilled authorization number (if Part A), physician order and pertinent medical records