West Ascension Parish Hospital

WAPH Wound Care Center
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PCL: Terri Keller

WOUND CARE REFERRAL FORM

PATIENT DEMOGRAPHICS *(may attach face sheet instead)*

Today's Date:		Patient DOB:	
Patient Name:		☐M ☐F	
Primary Care Physician:		Phone:	
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 receiving home health care?	☐No ☐Yes	Agency name:	
Auto or workers' compensation claim?	☐No ☐Yes	Date of injury:	
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.