Patient Referral Form

CENTER NAME, ADDRESS, CITY, STATE, ZIP
Phone: XXXXXXX – Fax: XXXXXX – Email: XXXXXX

Patient Name: _____ Referring Physician: _____

Date of Birth: _____ Physician Phone: _____

Phone Number: _____ Physician Fax: _____

Primary Insurance Plan & ID #: _____

Secondary Insurance Plan & ID #: _____

Priority Level: ❑ Urgent ❑ Routine

Diagnosis:

❑ Diabetic ulcer of lower extremity (location)_____

(must meet the criteria in the following 3 fields)

- ❑ Patient has Type I or II diabetes with a foot ulcer
- ❑ Wagner Wound Classification Grade: 3, 4, or 5
- ❑ Patient has received 30 days of standard wound care with little to no measurable signs of healing.

❑ Gangrene

❑ Chronic refractory osteomyelitis, unresponsive to conventional medical/surgical management

❑ Progressive necrotizing infection

❑ Acute peripheral arterial insufficiency

❑ Failed and/or compromised skin graft or flap

❑ Osteoradionecrosis

❑ Soft tissue radiation necrosis

- ❑ Cystitis
- ❑ Proctitis
- ❑ Enteritis
- ❑ Brain necrosis
- ❑ Other radiation damage: _____

❑ Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment

❑ Other condition: _____

Please fax or email relevant medical records, including a copy of the patient's demographic information.

Date: _____

Thank you for referring!