Wound Care Referral

P 989.790.2600 F 989.790.3311

Date: _____

Patient Name: _____DOB:_____Phone:_____

Referring provider name:_____

Phone#_____ Fax:_____

HISTORY & PHYSICAL EXAM

TYPE OF WOUNDS (check all that apply)

_____Acute

_____Chronic

_____Arterial

_____Venous

_____Diabetic

_____Traumatic

_____Surgical

_____Pressure Sores

_____Radiation

_____Pilonidal Cyst

_____Hidradenitis Suppurative

_____Atypical

_____Charcot Foot

_____Other_____

WOUND SESCRIPTION

Size:_____

Wound Duration:_____

Location:_____

Current Treatment, if any:_____

Any Imaging/US Performed?_____

_____

_____