ADVANCED®
WOUND CARE SPECIALISTS

Fax Referral To: (318) 346-8012

Please provide the following information
so we so we can proceed with scheduling provider visits:

- Past Medical History (or most recent H&P)
- Medications
- Labs
- Insurance

Date of Referral: _____

Referring Provider / Entity Information

Name: _____

Anticipated D/C Date: _____

Phone: _____ **Fax**: _____

Email: _____

ADVANCED®
WOUND CARE SPECIALISTS

Patient Information

Name: _____ **SSN**: _____ **DOB:** _____

Address: _____

Phone: _____

Primary Contact Name: _____ **Phone**: _____

Insurance: _____ **Policy #:** _____

Home Health Information

HH Name: _____ **Phone**: _____ **Fax**: _____

Nurse: _____ **Phone**: _____

Primary Care Provider: _____ Fax: _____

Pharmacy: _____

Wound Information

Location:

☐ Lower Extremity ☐ Upper Extremity ☐ Pressure Ulcer ☐ Surgical Wound

☐ Other: _____

Duration:

☐ <30 days ☐ 30–60 days ☐ >60 days

Type:

☐ Venous ☐ Diabetic ☐ Arterial ☐ Traumatic ☐ Other:

_____

Current Treatment: _____

_____

Services Requested: ☐ Initial Wound Assessment ☐ Debridement

☐ Compression Therapy ☐ Negative Pressure Therapy ☐ Dressing Changes

☐ Other: _____