United Wound Healing
Team-Centered Wound Care.™

New Patient Referral Form

PLEASE NOTE: Completed copy of this form and required documents must be received 72 hours prior to Wound Rounds to ensure patient registration and insurance authorization occurs.

Arizona intakes**AZ**@unitedwoundhealing.com
Idaho intakes**ID**@unitedwoundhealing.com
Oregon intakes**OR**@unitedwoundhealing.com
Texas intakes**TX**@unitedwoundhealing.com
Utah intakes**UT**@unitedwoundhealing.com
Washington intakes**WA**@unitedwoundhealingcom

Required documents
1. Most recent Face Sheet from referring facility.
2. Physician order for Wound Care Evaluation and Treatment *(i.e. We request [patient name] to be seen by United Wound Healing, PS for their wound care needs.)*

Facility Name _____

Your Name _____ Facility Contact Number _____

Patient Name _____ Date of Birth _____

TELEPHONE MD ORDER for "United Wound Healing to evaluate and treat as indicated," received

MD Name *(please print)* _____

Signed _____ Date _____

GENERAL PATIENT INFORMATION *(all information is REQUIRED):*

❍ Hospice ❍ Re-admission to United Wound Healing

Date of last influenza vaccination _____

THE FOLLOWING MUST BE COMPLETED FOR EACH WOUND LOCATION *(all information is REQUIRED):*

	Wound Location	Date Acquired	Type of Wound	Stage
Example:	*Sacrum*	*1/1/2019*	*Pressure Injury*	*4*
1				
2				
3				
4				

Please include additional wounds on a separate sheet.

Questions? If you have questions, please call us at 1-855-255-1750 | **Fax** 1-855-255-0905