Fort HealthCare Wound & Edema Center

400 Doctor's Court * Johnson Creek, WI 53038 * Phone (920) 699 – 4245 * Fax (920) 699 - 4748

PATIENT REFERRAL FACSIMILE TRANSMITTAL FORM

Date: _____ **Requesting Physician:** _____

PATIENT INFORMATION

Name: _____ **D.O.B.:** _____

Phone: _____ **Able to sign Own Consent?** ☐ **Yes** ☐ **No**

Primary Diagnosis & ICD9 Code: _____

Additional Patient Information: _____

INTENT OF VISIT (Clinical Question/Special Instructions):

Does the patient have a wound (any break in the skin)? ☐ **Yes** ☐ **No**

Does the patient have swelling, edema or lymphedema? ☐ **Yes** ☐ **No**

LEVEL OF CARE REQUESTED

☐ I am requesting consultation regarding Diagnosis and or Treatment Recommendation about the intent of visit stated above.

☐ I am requesting that you take over evaluation and management of the above stated medical condition (Defined as a Transfer of Care). I will continue to care for this patient's other medical conditions.

☐ I am requesting that you perform the specified Procedure/Test and return the patient to me for further care:

_____

PREFERRED RESPONSE

☐ Letter

☐ Other: _____

SUPPORTING DOCUMENTATION

The following documentation is required for consultation.

Attached To Fax	Not Available	
☐	☐	Current history and physical
☐	☐	List of current medications, dressings, wound care; etc.
☐	☐	Recent (<1 month) laboratory results; Pre-albumin, CBC, Basic Metabolic Panel, HbA1c
☐	☐	Insurance information

PROVIDER SIGNATURE: _____ **DATE:** _____