Wound Care Center Referral for Initial Evaluation*

*All subsequent visits will be scheduled through the Wound Center

Physician Office: Please fax this form and current H&P to (530) 344-5495

(FOR INITIAL INQUIRIES PRIOR TO FIRST VISIT, CALL (530) 344-5496

This document contains confidential patient information. Please notify us immediately if you are not the intended recipient.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Telephone Number: _____ MR#: _____

Diagnosis: _____ Ht: Wt: (required)

Primary Care Physician: _____

Brief History of wound / Special Physician Request: _____

_____

Please include with fax: ☒ H+P/PMH inc med list ☒ Diagnostic Imaging ☒ Most recent labs ☒ Other relevant info

Patient Insurance (Primary and Secondary): _____

PHYSICIAN WOUND CARE REFERRAL

☒ Refer to Wound Care Center for evaluation and treatment per Wound Care Team

Referring Physician (Print Name): _____ Referring Physician Phone #: _____

Referring Physician Signature: _____ Referring Physician Fax #: _____

PATIENT INSTRUCTIONS

1. Bring all current prescriptions and over-the-counter medications you are currently taking with you.

2. Arrive 15 minutes prior to the appointment time (to allow time for registration).

3. If you need to change or cancel your appointment, Please Call: (530) 344-5496

Marshall Medical Wound Care Center

1095 Marshall Way, Placerville, CA 95667

Telephone: (530) 344-5496