Wound Care Center Express Referral Form
PATIENT INTAKE DATA

Please send with this form the following:
*Current H&P *Current Med List
*Physician Orders *Insurance Cards

PATIENT INQUIRY INTAKE DATA – C 319F
REVISED (1/2021)

Today's Date: _____ Appointment Scheduled: _____

▲ Referring Physician or Service Provider	▲ Primary Care Physician
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone: Fax:	Phone: Fax:
Specialty:	Specialty:

Patient Name: _____ Primary Phone: _____
Address: _____ Secondary Phone: _____
City, State, Zip: _____
Email: _____ S.S. #: _____
DOB: _____/_____/_____ Age: ____ Sex: ____ Race _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic or Latino

▲ INSURANCE INFORMATION	Primary Insurance	Secondary Insurance
Name of Company		
Policy Number		

Does patient currently have an open wound(s)? ☐ No ☐ Yes How Many? _____ Location(s):_____
What type of wound(s)? _____ Is there drainage? ☐ No ☐ Yes
How Long has the wound been present?_____

Can the patient sign consent for self? ☐ No ☐ Yes If No, who is DPOA? _____
Ambulatory Status: ☐ Independent ☐ Assistive Device ☐ Stretcher ☐ Special Equipment to transfer needed

Is the Patient New to MMH System? ☐ No ☐ Yes

To be completed by Wound Care Center staff:
How Heard? ☐Physician ☐Hospitalist ☐ Emergency Department ☐Self-Referred ☐Hospital Partner ☐Other Clinician:
☐Skilled Nursing Facility ☐Nursing Home ☐Home Health ☐Other Hospital ☐Other: _____

Intake completed by: _____ Date: _____ Time:_____ Packet Mailed: ☐ N/A ☐ Yes

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