McLaren
BAY REGION

4 Columbus Avenue, Suite 310
Bay City, Michigan 48708
989-393-2870

# WOUND CARE CENTER
# NEW PATIENT REFERRAL FORM

## PLEASE RETURN COMPLETED FORM VIA FAX (989-894-8865)

Name:_____ Date of Birth:_____

Patient Address:_____
City:_____ Zip Code:_____

Patient Phone Number:_____

Referring Physician Name:_____ Telephone Number:_____

Primary/Family Physician:_____ Telephone Number:_____

Primary INSURANCE:_____
Contract ID Number _____
Phone Number: _____

Secondary INSURANCE: _____
Contract ID Number _____
Phone Number: _____

Location of Wound: _____ Date of Wound Onset:_____

Diabetes: ☐ YES NO ☐ History of Radiation: ☐ YES ☐ NO

**WOUND TYPE**

| | | |
|---|---|---|
| ☐ Arterial Ulcer | ☐ Cellulitis | ☐ Wound Dehiscence |
| ☐ Decubitus Ulcer | ☐ Diabetic Ulcer | ☐ Hemorrhagic Cystitis |
| ☐ Insect Bite | ☐ Osteoradionecrosis | ☐ Comprised or failed flap or graft |
| ☐ Osteomyelitis | ☐ Post-Operative Wound | ☐ Pressure Ulcer |
| ☐ Peripheral Vascular Disease | ☐ Radiation Proctitis/Cystisis | ☐ Soft Tissue Necrosis |
| ☐ Thermal Burns | ☐ Acute Peripheral Arterial Insuffiency | ☐ Acute traumatic peripheral ischemia |
| ☐ Actinomycosis | | |

Additional Information:_____
_____
_____

Additional Information Needed (if available, please fax results, etc. with this form)
Last progress note/History & Physical ☐ Culture Results ☐ MRI/Bone Scan Results
Most recent blood work results ☐ Vascular Study Results

Not part of the permanent medical record