Use Ball Point Pen Only

Wound Care Center – Randolph Health Outpatient Center
Referral Form

Date:_____ Patient DOB:_____
Patient First Name:_____ Last Name:_____
Insurance: _____
Authorization Number:_____ (Indicate "None" if not required)
Service Date Range for Authorization: _____
# of visits approved:_____
Referring Provider Name: _____
Facility/Practice Name:_____
Office Ph. Number: _____ Office Fax Number:_____
Office Contact:_____

Please check appropriate diagnosis below

□ Diabetic Ulcer **Location:**_____ **ICD-10 Code(s):** _____
□ Surgical Wounds (incisions or fistula) **Location:**_____ **ICD-10 Code(s):** _____
□ Venous Ulcer **Location:**_____ **ICD-10 Code(s):** _____
□ Pressure Ulcer **Location:**_____ **ICD-10 Code(s):** _____
□ Arterial Ulcers **Location:**_____ **ICD-10 Code(s):** _____
□ **Acute trauma related wounds:**
- □ Burns **Location:**_____ **ICD-10 Code(s):**_____
- □ Blisters **Location:**_____ **ICD-10 Code(s):**_____
- □ Perineal Dermatitis **Location:**_____ **ICD-10 Code(s):**_____
- □ Lacerations **Location:**_____ **ICD-10 Code(s):**_____

□ Lymphedema _____ **Location:**_____ **ICD-10 Code(s):**_____

Please fax the items below to 336-633-7925

- Demographic Information and a copy of front and back of Insurance Card(s)
- History and Physical with current medication list
- Any recent lab test results
- Any test results specific to the wound
- Insurance Authorization Confirmation (if required). The referring office will be responsible for obtaining all insurance authorizations.

***Please note that an incomplete referral will delay scheduling.**
Wound Care Office Phone 336-328-HEAL (4325)

Randolph Health