

Use Ball Point Pen Only

Wound Care Center – Randolph Health Outpatient Center
Referral Form

Date: _____

Patient First Name: _____ Last Name: _____

Patient DOB: _____

Patient Ph. Number: _____

Insurance: _____

Referring Provider Name: _____

Facility/Practice Name: _____

Office Ph. Number: _____ Office Fax Number: _____

Office Contact: _____

Primary Care Physician _____

Please check appropriate diagnosis below

- | | | |
|---|-----------------|---------------|
| <input type="checkbox"/> Diabetic Ulcer | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Surgical Wounds (incisions or fistula) | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Venous Ulcer | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Pressure Ulcer | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Arterial Ulcers | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Acute trauma related wounds: | | |
| <input type="checkbox"/> Burns | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Blisters | Location: _____ | ICD-10: _____ |
| <input type="checkbox"/> Lacerations | Location: _____ | ICD-10: _____ |

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

***Please note that an incomplete referral will delay scheduling.**

Wound Care Office Phone 336-328-HEAL (4325)

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WOUNDREF

Original 11/22
Wound Care Referral Form