RESTORE FIRST HEALTH

Advanced Wound Care Referral

Referral Source _____ Contact _____ Phone _____

Current Home Care/Nursing Home Manager _____

Patient Information *(*required field)*

*Patient Full Name _____

*DOB _____*Medicare#/MBI _____

*Address (of care provision) _____

*Emergency Contact _____ *Phone_____

*Wound Measurements _____

*Primary Reason for Referral _____

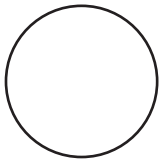
_____

*Healthcare practitioner who will oversee wound care services_____

Orders

Criteria

- Wound MUST be LARGER than 2cm x 2cm
- Open wound
- Chronic wound that has failed at least 4+ weeks of conventional treatment



Additional orders or information about the patient you would like us to know in order to provide excellent care.

Healthcare Practitioner signature and credentials _____

Print name _____ Date _____

Requested Information: Please include these documents to ensure a safe patient transition

- Recent clinical notes, H&P, labs
- Current Medication List
- Most recent assessment of wound/primary reason for referral
- Dimensions of wound

Please submit your completed form by FAX at (316) 330-5353, or call us at (316) 330-5353.