Advanced Wound Center

Outpatient referral request

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Last name: _____ First name: _____
Date of Birth: _____ Phone: _____
City: _____ State: _____ Zip: _____ _____

REFERRING PHYSICIAN

Physician name: _____ Phone:_____ FAX: _____

SERVICES REQUESTED

☐ Wound care evaluation with follow-up treatment

PATIENT HISTORY

Wound location: ☐ Foot ☐ Leg ☐ Left ☐ Right ☐ Other:
Chief complaint: _____
When & how wound acquired: _____
Does patient have diabetes? _____

WOUND TREATMENT HISTORY

☐ Surgical Procedure Date: _____ ☐ Compression Therapy Date: _____
☐ Antibiotics Date: _____

PLEASE FAX OR SEND ANY OF THE FOLLOWING INFORMATION

- History and physical
- Pathology report
- EKG
- Operative report
- Vascular assessment
- ABI results
- Cultures
- Labs (cbc/sma 20/sed rate/hgb a1c)
- Radiology (X-ray/bone scan/ chest X-ray)
- List of medications (*as known by office*)

PLEASE INSTRUCT THE PATIENT ON THE FOLLOWING

- Bring all medications or a list of medications with dose and frequency information to their appointment.•
- Bring insurance cards and any other payor information.
- The evaluation will take approximately 2 hours. Arrive 15 minutes early in order to complete the registration process.
- If patient is too debilitated to sign authorization permits, please instruct a family member, preferably one with power of attorney, to accompany patient.

[URGENT / EMERGENT REFERRALS REQUIRE PHYSICIAN TO PHYSICIAN CONTACT.]