WoundCare Innovators
8700 Crownhill Blvd, Suite 405 San Antonio, TX 78209
Phone: (210) 800-2630 | Fax**:** (949) 864-3161
Email: contact@woundcareinnov.com

Patient Referral Form

Please complete this form to refer a patient to Woundcare Innovators Clinic. Attach relevant clinical documentation including history, wound details, and insurance card.

Patient Information

Patient Name: _____

Date of Birth: _____ Gender: _____ SSN: _____

Phone: _____ Alternate Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Medicare ID#_____

Secondary Insurance: _____ ID: _____

Preferred Language: _____

Referring Provider / Facility Information

Referring Facility (Check one): □ PCP □ Nursing Home □ Group Home

□ Home Health Agency

Facility Name: _____

Referring Provider Name: _____

NPI#: _____ Phone: _____

Fax: _____ Email: _____

Facility Address: _____

City: _____ State: _____ ZIP: _____

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Clinical Information

Diagnosis: _____

Wound Type: □ Diabetic □ Venous □ Arterial □ Pressure □ Surgical □ Other: _____

Location of Wound(s): _____

Duration of Wound(s): _____

Wound Size (if known): L:____ cm W:____ cm D:____ cm

Signs of Infection: □ Yes □ No If yes, specify: _____

Past Treatment Provided: _____

Reason for Referral: □ Evaluation □ Treatment □ Second Opinion □ Other: _____

Required Attachments

- - Recent History and Physical or Provider Notes
- - Wound Documentation (Photos, Measurements if available)
- - Insurance Card Copy (Front and Back)
- - Medication List
- - Any Recent Labs or Imaging Reports

Signature

Referring Provider Signature: _____ Date: _____

Printed Name: _____