ADVANCED Wound Therapy

Referral Form

Patient's Name: _____ Date of Referral: _____
Date of Birth: _____ Patient's Address: _____
Telephone Number: _____ _____
Social Security #: _____ _____
Primary Ins: _____ Policy# _____
Secondary Ins: _____ Policy# _____
Tertiary Ins: _____ Policy# _____

Referral To: Advanced Wound Therapy Fax: 539.399.7560 [referrals@advancedwoundtherapy.com]

Tulsa Office
Phone: 918.592.9020

OKC Office
Phone: 405.825.9020

Referred By: [*Service provider's name, address, and telephone number*]

_____
_____
_____

Reason for Referral:

_____
_____
_____

Authorization: ☐ **Evaluate and Treat**

Dx Codes:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please include these Details:

- ☐ Patient Demographic/Face Sheet
- ☐ Any Wound History with Photos
  - ○ Detailed Wound Notes
  - ○ History & Physical (H&P)
- ☐ Medication List + Allergies
- ☐ Current Diagnosis & Co-morbidities
- ☐ Any recent Surgery dates (with surgical notes)

(Orders)
Fax: 539.399.7572