INTEGRATED SKIN INSTITUTE

Wound Care Referral Form

Fax: 615-622-8905 Phone: 615-314-1699
integratedskin.org

Patient Information:

Name _____ **DOB** _____ **Phone** _____
Address _____
City _____ **State** _____ **Zip** _____

Primary Care Provider: _____
Additional Specialists (i.e.- endocrinologist, cardiologist, vascular surgeon): _____
Home Health Agency: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance _____
Member ID/Policy: _____ Member ID/Policy: _____

***Wound Information*:**

Is this a new wound (circle) Yes No **Previous Wound Care (circle):** Yes No

Wound Location(s): _____ **Wound Duration:** _____
Wound size (Length x Width x Depth), in cm _____

Suspected Etiology (cause): pressure / arterial / venous / diabetic / post-surgical / other

Wound Management History:

Current/previous provider treating wound: _____

Prior Treatments (Debridement, Dressings, Compression, Negative Pressure, Oxygen, etc…):
_____

Prior Labs: please attach (i.e.- CBC w/diff, CMP, A1C, Blood Glucose, Albumin, Iron Panel, Vitamin/Minerals)
Prior Work-Up: please attach (i.e.- recent ABI, venous duplex studies, imaging studies, etc..)
Patient Smoking (tobacco) History: active / former / none / unknown

Care coordinator signature: _____ **Date:** _____

Please Print Name: _____

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1.) FAX this form (to 615-622-8905) with the following:
- Health insurance card(s) -Demographics Sheet -All chart notes -Prior studies/labs

2.) EMAIL wound photos to: photos@integratedskin.org
In the subject of email please state: "Wound Photos - Patient Last Name, Patient First Name. DOB"
- Most recent wound photo(s) in color showing size - Past photos of wound (if available)