Referral Form

TREATMENT LOCATIONS

877-295-2273

Denver City, TX

Muleshoe, TX

Palacios, TX

Port Lavaca, TX

Yoakum, TX

Lovington, NM

OTHER TREATMENT LOCATIONS

Arkansas

Kansas

Louisiana

Mississippi

Oklahoma

Patient: ______________________________ **Date:** __________
Last First MI

Address: ______________________________
City State Zip

Phone: __________ **Cell:** __________ ❐ **M** ❐ **F** **DOB:** __________

Alternate Contact: __________ Relation: __________

Phone: __________ Cell: __________

Primary Insurance Name __________ SSN: __________

Policy # __________ Group # __________

Secondary Insurance Name __________

Policy # __________ Group # __________

Home Health: ❐ yes ❐ no Agency Name: __________ Phone: __________

Hospice: ❐ yes ❐ no Agency Name: __________ Phone: __________

Nursing Home: ❐ yes ❐ no Facility Name: __________ Phone: __________

Skilled Bed: ❐ yes ❐ no Skilled Bed End Date: __________

Dialysis: ❐ yes ❐ no If yes, what days?__________ Facility Name: __________

❐ **WOUND Care Dx. / Reason for Referral** __________

Number of wounds? ______ Location of wounds __________

Is patient bedbound? ❐ yes ❐ no

❐ **PATIENT CAN SIGN CONSENT** / ❐ **NOT ABLE TO SIGN CONSENT**

Transportation Method: ❐ **PATIENT** ❐ **FAMILY** ❐ **OTHER** __________

❐ **AMBULATORY** ❐ **USES WHEELCHAIR** ❐ **NEEDS STRETCHER**

❐ **ALLERGIES:** __________

Has patient seen a vascular surgeon? ❐ yes ❐ no If yes, which one? __________

Medication regimen included? ❐ yes ❐ no Lab/test results included? ❐ yes ❐ no

Any additional information: __________

____

____

Please FAX to (888) 835-6946 or (504) 835-6946

Referral Source Name __________ (Print) **Phone:** __________

Referral Source Type ❐Physician ❐Discharge Planner ❐Nurse Practitioner ❐Nursing Home ❐Home Health ❐Other__________

Name of Person Completing This Form __________ **Phone:** __________

Primary Care Physician __________ **Phone:** __________