

Referral Form



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 Fax:(509)289-5782
 info@excelledhealing.com

Date _____

Referral Source _____ Fax _____ Phone _____

PATIENT INFORMATION					
Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone	Date of Birth		
Scheduling contact if other than patient		Relationship to patient	Phone		
Address	City	State	Zip	Rm # or Gate Code	
Is patient currently in an assisted living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name of ALF		Name of ALF Care Coordinator			
POA		Phone			
Billing Address	City	State	Zip		

Notes:

INSURANCE INFORMATION **Please include copy of insurance card/s**		
Primary Insurance	Member ID	Phone
Secondary Insurance	Member ID	Phone

CARE PARTNERS		
Home Health or Hospice Agency	Phone	Order Fax
	Case Manager	CM Phone
Days being seen by Home Health or Hospice		

Primary Care Physician	Phone
	Fax

Recent Facility Discharge? If yes, include name and discharge date

SUSPECTED WOUND ETIOLOGY			
Venous	Arterial	Thermal Injury	Trauma
Malignant	Neuropathic	Unknown	Other
Pressure	Diabetic	Surgical	
Has this wound been treated by healthcare professionals?		Yes	No
If so, for what period of time?		<30 days	30-90 days >90days

COMORBIDITIES			
Diabetes	Hypertension	Venous Insufficiency	Malnutrition
Moderate to severe mobility restriction		Edema or lymphedema	
Arterial Insufficiency	Suspected infection at the wound site		

