Nor-Lea Hospital District

Wound Clinic
Toll-free Phone: (877) 295-2273
Fax: (888) 835-6946

1600 N MAIN | LOVINGTON, NM 88260 | NOR-LEA.ORG

WOUND CLINIC REFERRAL FORM

Patient: ______________________ (LAST) ______________________ (FIRST) ______ (MI) Date: __________

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 or ICD-9 / Reason for Referral:** __________

Number of wounds: __________ Location of Wounds: __________

☐ **PATIENT CAN SIGN CONSENT /** ☐ **NOT ABLE TO SIGN CONSENT / Reason:** __________

Arrival Method: ☐ **AMBULATORY** ☐ **WHEELCHAIR** ☐ **STRETCHER**

Transfer Assistance Required: ☐ None ☐ Minimal Assist ☐ Full Assist

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

Any additional information: __________

Referral Source: __________ (PLEASE PRINT) Phone: __________

Referral Source: ☐ Physician ☐ Discharge Planner ☐ Nursing Home ☐ Home Health ☐ Nurse Practitioner ☐ Other: __________

Name of person completing this form: __________ Phone: __________

Primary Care Physician: __________ Phone: __________

Ordering Physician: __________ Signature: __________ Phone: __________

PLEASE FAX TO: (888) 835-6946 or (504) 835-6946