WOUND X MOBILE
ACCELERATE YOUR HEALING

443-948-9600
info@woundxmobile.com
woundxmobile.com

PATIENT REFERRAL FORM

ATTENTION: CASE MANAGERS, DISCHARGE PLANNERS, REFERRAL COORDINATORS AND UTILIZATION MANAGERS
ALL ITEMS MARKED WITH (*) ARE REQUIRED.

REFERRING PROVIDER INFORMATION*

PERSON COMPLETING THIS FORM: NAME: _____ PHONE#: _____

PATIENT AWARE OF REFERRAL TO WOUNDXMOBILE ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____ FAX #: _____

REFERRING PHYSICIAN (IF OTHER THAN PRIMARY): _____

REFERRING FACILITY NAME: _____

REFERRING FACILITY PHONE #: _____ REFERRING FACILITY E-MAIL ADDRESS: _____

IPA/MSO (IF APPLICABLE): _____

PATIENT INFORMATION

IS THE PATIENT'S PCP AWARE THAT WOUNDXMOBILE WILL BE CONTACTING THE PATIENT FOR TREATMENT?PATIENT ☐ YES ☐ NO

NAME: _____ D.O.B.: _____

PATIENT ADDRESS*: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT PHONE*: _____ PATIENT EMAIL: _____

CAREGIVER/FAMILY PHONE*: _____ CAREGIVER/FAMILY EMAIL*: _____

CURRENT LOCATION OF PATIENT: _____

PATIENT LOCATION: ☐ SNF/ALF ☐ HOME NUMBER OF VISITS*: ☐ 2 ☐ 8 ☐ 12

PATIENT SKILLED AUTHORIZATION # (IF PART A): _____

ELIGIBLE INSURANCE INFORMATION*

DATE OF REFERRAL: _____ PRIMARY INSURANCE*: _____

SECONDARY INSURANCE: _____ PLAN TYPE: _____

MEMBER ID: _____

REASON FOR REFERRAL

CPT CODE*: _____ WOUND LOCATION: _____

WOUND TYPE: ☐ ARTERIAL ☐ DIABETIC ☐ PRESSURE ☐ SURGICAL ☐ TRAUMA ☐ VENOUS

☐ OTHER: _____

REFERRALS FROM PCP: include patient facesheet/demographics and pertinent medical records
REFERRALS FROM SNF: include patient facesheet/demographics, patient skilled authorization number (if Part A), physician order and pertinent medical records