

Advanced Wound Healing Center

McKenzie Willamette Medical Center

Date: _____

Referring Physician: _____

Phone: _____ Fax: _____

Patient Information

Patient Name: _____

Patient Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

Reason for Referral:

Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Acute peripheral arterial insufficiency | <input type="checkbox"/> Acute traumatic peripheral ischemia | <input type="checkbox"/> Actinomycosis |
| <input type="checkbox"/> Arterial Ulcer | <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Wound dehiscence |
| <input type="checkbox"/> Decubitus Ulcer | <input type="checkbox"/> Diabetic Wound Lower Extremity | <input type="checkbox"/> Compromised or failed flap / graft |
| <input type="checkbox"/> Insect Bite | <input type="checkbox"/> Osteoradionecrosis | <input type="checkbox"/> Hemorrhagic Cystitis |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Post Operative Wound | <input type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> Radiation Proctitis | <input type="checkbox"/> Soft Tissue Radionecrosis | <input type="checkbox"/> Radiation Injury - Other |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Venous Stasis | <input type="checkbox"/> Thermal Burn |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Please include Patient Face Sheet Demographics, Labs (if within last 3 months), Vascular studies, H&P, and any Wound Care notes. Thank you.

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Revised 12/2009