QUINCY VALLEY MEDICAL CENTER

Wound Care Referral

Please fax referral form with patient face sheet, insurance information, and recent office visit notes along with recent lab work to (509) 787-4865

When possible, referrals should be placed by the patient's PCP, per our policy. Referring providers are asked to review cultures and prescribe antibiotics accordingly.

Referring Provider:_____

Phone Number:_____ **Fax Number:**_____

Patient Name:_____

DOB:_____ **Phone Number:**_____

Type of Wound:

❑ Diabetic Foot Ulcer	❑ Venous Leg Ulcer	❑ Pressure Ulcer
❑ Skin Tears	❑ Surgical	❑ Other

Wound Location:_____**Duration of Wound:**_____

Size of Wound:_____

History of MRSA/MSSA: ❑ Yes ❑ No

******Please note wounds below the knee will require a recent Ankle Brachial Index Study***

Right Leg ABI:_____ **Left Leg ABI:**_____

Urgency:

❑ A Couple of Days	❑ Within a Week	❑ Within a Month

Patient currently enrolled with Home Health Services: ❑ Yes ❑ No