PROVIDENCE Health & Services

PAMC WOUND CARE SERVICES PROVIDER REFERRAL/ORDERS

Outpatient Wound/Ostomy Center
Phone: (907) 212-3651
Fax: (907) 212-4898

PATIENT DETAILS

Patient Legal Name (First, Middle, Last): _____

Sex: Male # Female # Date of Birth:___ /___ /_____Needs Interpreter? Yes # Language: _____

SSN:_____-_____-_____Home Phone: (_____)_ Cell Phone: (_____) _____

Address: _____

PATIENT INSURANCE DETAILS

Insurance Name and Plan/Network:_____Group #: _____

Subscriber Name/ID:_____Subscriber DOB: / /_____

Authorization #: _____

SERVICE DETAILS

Service Ordered: _____
evaluate and treatopen wound; # culture/sensitivity; # selective/non-selective debridement; # ostomy

Reason for Exam: _____

Service Date:_____/_____/_____ Priority: Normal # STAT # Patient Status: Inpatient # Outpatient #

Ordering Provider:_____Phone:_____; Fax: _____

Primary Care (PCP):_____Phone:_____; Fax: _____

ICD 10:_____;_____;_____; Diagnosis Description: _____

CPT:_____;_____;_____; Procedure Description: _____

Allergies (list all): _____

Special equipment or mobility needs: _____

_____

Comments: _____

_____

Thank you for choosing the Providence Outpatient Wound Center, to better serve our patient's needs we recommend baseline vascular testing for all chronic lower extremity wounds. i.e. ABI within last 5 years, TBI, if patient is diabetic or ESRD.

FAX most recent X-rays/cultures/medication list/vascular studies to (907) 212-4898

Provider Signature: X _____

Print Provider name: _____

Date:_____/_____/_____Time:_____:_____

PLACE PATIENT
ID LABEL HERE