Northfield Hospital + Clinics
Wound Healing

Express Referral Form

Patient's name: _____ Date of birth: _____

Patient's address: _____

City: _____ State: _____ Zip code: _____

Patient's phone number: _____

Referring provider name: _____

Referring provider phone number: _____ Fax: _____

Primary provider name: _____

Primary provider phone number: _____ Fax: _____

Location of wound: _____

Diabetic? ❑ Yes ❑ No ❑ Unknown

History of radiation? ❑ Yes ❑ No ❑ Unknown

Currently on IV antibiotics? ❑ Yes ❑ No ❑ Unknown

Patient transfers ❑ Ambulatory ❑ Wheelchair ❑ Stretcher ❑ Mechanical lift

Current with home health care. ❑ Yes ❑ No If yes, name of agency_____

Additional information: _____

_____

_____

Please provide the following documentation:

1. Demographics page including insurance information.
2. Progress note with information on wound assessment if available.
3. Any recent labs or imaging related to the wound if available.
4. Problem list and current medication list.

PLEASE RETURN COMPLETED FORM VIA FAX 507-646-6901