

# Specialty Service Referral Wound Care

SBL Advanced Wound Care  
1000 Health Center Dr., Suite 302 • Mattoon, IL 61938  
217-238-4850 • Fax 217-238-4855



## REFERRING PROVIDER

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Reason for Referral \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Last 4# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_ County \_\_\_\_\_  
Insurance Carrier Primary \_\_\_\_\_ Secondary \_\_\_\_\_  
If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # \_\_\_\_\_  
Work Related  Yes  No If yes, Employer \_\_\_\_\_ Contact \_\_\_\_\_  
Work Comp Carrier \_\_\_\_\_ Contact \_\_\_\_\_

## INFORMATION NEEDED

Please include all the information below.

- Provider Notes
- Procedure Reports
- Appropriate Laboratory Reports
- Appropriate Imaging Reports
- Medication and Allergy Lists

### Wound Treatment History

- Surgical Debridement Date \_\_\_\_\_
- Revascularization Date \_\_\_\_\_
- Skin Graft Date \_\_\_\_\_
- Antibiotics Date \_\_\_\_\_
- Amputation Date \_\_\_\_\_

### Appointment Requested

- Wound Evaluation and Treatment
- Hyperbaric Oxygen Therapy

## REFERRING RESPONSE

- Patient Scheduled  
Provider \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Comment \_\_\_\_\_
- Patient NOT Scheduled  
Additional Information Required \_\_\_\_\_  
Other Reason \_\_\_\_\_