ADVANCED
TOTAL WOUND CARE

912 S. Euclid Avenue, Bay City, MI 48706
Phone: 989-391-9872 Fax: 989-391-9875

NEW PATIENT REFERRAL FORM

Today's Date:_____

Patient Name:_____ DOB:_____

Address:_____

Phone:_____ Cell:_____

PLEASE INCLUDE PATIENT'S DEMOGRAPHICS, ALL LABS, OFFICE NOTES, TESTING, IF NEEDED, INSURANCE REFERRAL AND COPY OF INSURANCE CARDS. IF NOT COMPLETED, REFERRAL WILL NOT BE PROCESSED. A 24-HOUR NOTICE OF CANCELLATION IS REQUIRED.

Referring Physician:_____

Phone:_____Fax:_____

PATIENT INFORMATION (PLEASE PRINT):

Last Name	First Name	MI	DOB	Sex(M/F)

Primary Diagnosis

Secondary Diagnosis

Provider Signature:_____Date:_____Time:_____

SERVICES REQUESTED

- ☐ Comprehensive New Patient Evaluation – Wound Care
- ☐ Complex Wound Care (not to include routine post-operative management)
- ☐ Venous Stasis Management

Appointment Date:_____ Time:_____ Referring Provider Notified: Date:_____

Patient Notification Date:_____ Staff Initials:_____ Time:_____

Insurance Verified: Yes_____ No_____ Method:_____