WILSON MEDICAL
REGIONAL WOUND CARE &
HYPERBARIC MEDICINE CENTER

2600 Ottawa Road
Neodesha, KS 66757
Phone: 620.325.8393
Fax: 630.325.8463

Express Referral Form

Return COMPLETED FORM with:
Current H&P with **Last Office Note**, **Medication List**, **Labs, Demographic Information**
with **INSURANCE CARD COPIES- FRONT & BACK**
FAX to 620.325.8463
Thank You

Date: _____

Patient Information

Name:_____DOB:_____ Phone: _____

Primary Insurance: _____ Secondary:_____

Referring Provider Information

Name: _____Phone: _____Fax:_____

Please tell us:

Open Wound: Yes or No
# of Wounds:_____
Open Wound Locations:_____
When did Wound Occur:_____
How did Wound Occur:_____

Prior Treatment Received: Yes or No
Where and What Tpe:_____
Ambulatory: Yes or No
Transfer Ability_____

- ☐ Diabetic Ulcer
- ☐ Post Surgical Wound
- ☐ Pressure Ulcer
- ☐ Radiation Wound
- ☐ Skin Tear
- ☐ Trauma Wound
- ☐ Venous Ulcer
- ☐ Compromised Skin Graft
- ☐ Crush Injury
- ☐ Necrotizing Fascitis
- ☐ Osteomyelitis
- ☐ Osteo Radionecrosis
- ☐ Soft Tissue Radionecrosis
- ☐ Wound with no improvement within 30 days

Referral for Non-wound? Yes ___ No ___

Request: TCOM Yes___ No ___ ABI Yes ___ No ___
Please indicate: Unilateral _____ Bilateral _____

Additional comments:

_____

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