McLaren PORT HURON

1221 Pine Grove Ave. Port Huron, MI 48060

Patient Identification

Wound Healing Center Physician Referral Fax Form

Date:	Referring Physician:
Phone Number:	How heard:
Has the patient been seen at the Wound Center before?	☐ YES ☐ NO
Has patient been seen by Dr. Dencklau or Dr. Hussain in the past?	☐ YES ☐ NO

Patient Name:		Primary Phone:	
Address:		Secondary Phone:	
City, State, ZIP:			
Email:	DOB:	Age:	Sex: Race:
Primary Care Physician			

Does patient sign his/her own papers? ☐ YES ☐ NO	
Guardian/Durable Power of Attorney:	**Phone:**
Please remind patient/guardian to bring guardianship/POA papers.	

Insurance:	Primary Insurance	Secondary Insurance
Name of Company:		
Policy Number:		
Worker's Compensation related?	☐ YES ☐ NO	
If yes, indicate carrier:		Accident Date:

History of Diabetes: ☐ YES ☐ NO		
Has there been any lab work in the past month?	☐ YES ☐ NO	Ordering Physician:
Any tests for circulation on leg(s)?	☐ YES ☐ NO	
Test ordered by?	Test done where?	

PLEASE SEND A COPY OF PATIENT'S HISTORY & PHYSICAL, MOST RECENT LABS, VASCULAR STUDIES OR RADIOGRAPHS (IF APPLICABLE)

Any problems with infection, swelling or other? (If so, what)	
Open wound(s)? ☐ YES ☐ NO	How many?
Where is (are) the wound(s) located?	

Please document the diagnosis code (for insurance authorization): _____

Does the patient have any special accomodation needs?	Interpreter	Isolation Precautions
Other:		

Please fax this information to 810-989-3331

We will notify you when patient's first appointment has been scheduled. Thank you for your referral.

For Office Use Only

☐ CM Log ☐ Meditech ☐ Ins Auth ☐ Iheal ☐ Mailed Letter ☐ MR#