Dr. Jeffrey Winter

Vicky Bryan MSN, CWON, FNP-C

VSA Wound 360

Austell Canton Hiram Marietta Woodstock

WOUND CARE REFERRAL

T: 678.626.5426 F: 678-391-5083

Patient:_____ Insurance/Policy # _____

Address:_____ City/State _____ Zip _____

Patient Phone #_____ DOB: _____ SS# _____

• Attach Demographics•

Ordering Physician: _____ Office Phone #_____ Referral Date _____

Name of contact for Referral:_____ Referral Location: Office / Home Care / Nursing Home

Mobility Status: Ambulatory / Wheelchair / Stretcher

Wound Type: Diabetic Traumatic Injury Lymphedema Surgical Pressure
Peripheral Artery Disease Venous Disease Unknown

Wound Location(s): _____ Duration: _____

Diabetes: Y / N Recent HbA1c_____ Date _____ Albumin _____ Date _____

Diabetes: Y / N Wound Culture Performed: Y / N Date:_____ Copy of Results: Y / N

Antibiotic Treatment: _____

Current Wound Care Treatment: _____

Referral needs:

☐ Assume Treatment for Advanced Wound Care needs

☐ Complete Vascular Evaluation for Active Wound

Provider Signature _____ Date _____