Brookings HEALTH SYSTEM
Wound Center

Center Name and Contact Information:

Wound Center
300 22nd Avenue | Brookings, SD 57006
FAX: 605-696-8814 **PHONE:** 605-696-8068

WOUND CENTER REFERRAL FORM

Today's Date:		Patient DOB:	
Patient Name:		☐M ☐F	
Primary Care Physician:		Phone:	
PATIENT DEMOGRAPHICS (may attach face sheet instead)			
Address:	City:	State:	Zip:
Phone:	Alternate Phone:		
PATIENT INSURANCE INFORMATION (may attach face sheet instead)			
Primary:		ID#:	Group#:
Phone:			
Secondary:		ID#:	Group#:
Phone:			
Is patient in a nursing home?	☐ No ☐ Yes	Facility name:	
Is patient a SNF resident?	☐ No ☐ Yes	Facility name:	
Is patient receiving home health care?	☐ No ☐ Yes	Facility name:	
Auto or workman's compensation claim	☐ No ☐ Yes		
Is patient in the hospital? ☐ No ☐ Yes	Room No.	Is this a swing bed? ☐ No ☐ Yes	

REFERRAL REASON	***Wound Location***	***Wound Location***
☐ Arterial/ischemic ulcer		☐ Compromised skin graft or flap
☐ Diabetic foot ulcer		☐ Crush injury
☐ Pressure injuries/ulcer		☐ Non-healing, post-surgical wound
☐ Venous ulcer		☐ Traumatic wound
☐ Post-radiation ulcer/wound		☐ Other
ADDITIONAL COMMENTS:		

Is patient on antibiotics?	☐ No ☐ Yes	RX name:
Is patient on blood thinners?	☐ No ☐ Yes	RX name:

REFERRER INFORMATION				
Name:		Phone:		Fax:
Referral Source:	☐ Physician	☐ Discharge Planner	☐ Nursing Home	☐ Nurse Practitioner
	☐ Home Health	☐ PA	☐ Other:	

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.

CONFIDENTIAL NOTICE: This facsimile, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or information that is otherwise protected by law. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original facsimile.