Charleston
Wound Care

Patient Referral Form

Date: _____

Referring Physician _____

Phone _____ **Fax** _____

Patient Name: _____

Patient Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

Reason for Referral: (Please check all that apply.)

- ☐ Arterial Ulcer
- ☐ Burn
- ☐ Cellulitis
- ☐ Compromised flap/graft
- ☐ Diabetic Ulcer Lower Extremity
- ☐ Insect Bite
- ☐ Osteomyelitis
- ☐ Peripheral Vascular Disease
- ☐ Post Operative Wound
- ☐ Pressure Ulcer
- ☐ Trauma Wound
- ☐ Venous Stasis Ulcer
- ☐ Wound Dehiscence
- ☐ Other:_____

Please include the following information with your fax: demographic sheet, H&P, progress notes, labs, vascular studies, etc.

Thank you for your referral!

Please call with any questions.

Dr. Christopher Michaelis, DO

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charlestonwoundcare.com