Referral For Treatment

MK WOUND & LIMB SALVAGE

Phone: 316-910-0024 **Fax: 316-910-0023**

MK WOUND & LIMB SALVAGE

Dr. Justin Gooden

Patient Name: _____ DOB ___/___/_____ Age _____ Sex _____

Patient Phone: _____ City _____ State _____ Zip _____

Primary Insurance: _____ Policy # _____

Secondary Insurance: _____ Policy # _____

Is patient diabetic?____ Does patient have a pacemaker?____ Does patient have home health? ___

Is patient ambulatory? ____ Does patient use a wheelchair or walker? ____

Home Health Agency:_____

Resason for Referral: [ ] Wound Care

Indication for Wound Care

- ☐ Ischemic ulcer
- ☐ Pressure ulcer
- ☐ Diabetic ulcer
- ☐ Venous ulcer
- ☐ Non-healing surgical wound
- ☐ Traumatic wound
- ☐ Wound flap
- ☐ Other (_____)

Underlying Issues

- ☐ Diabetes
- ☐ Trauma
- ☐ Lymphedema
- ☐ Prior Amputation
- ☐ Other_____

Wound Location: _____

Comments: _____

_____

_____

Please send with patient or fax a list of medications, recent labs and x-ray, H&P and progress notes.

Please send referral:
Fax: 316-910-0023
info@mkwound.com

_____
Signature Date: