WOUND CARE PATIENT HISTORY FORM

Fax: 850-224-9356
Email: info@WCRxHealth.com

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name: ______________________________

First Name: ____________________________ **MI:** _________

Today's Date: ____________________________

Doctor that referred you ____________________________

Date of Birth: ____________________________

PRIMARY INS: ____________________________________
ID #: ____________________ **Group #:** _________________
SECONDARY INS: __________________________________
ID #: ____________________ **Group #:** _________________

Chief Complaint

Please describe wound and relevant facts

____

____

Is this wound chronic? Y N

History of Present Illness

Please answer the following questions

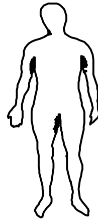
Location of the wound?

Foot Back Leg

Other: ________________________

____

Front **Back**



Onset of present wound?

_______ Days ago
_______ Weeks ago
_______ Months ago
_______ Years ago

Have you been treated for present wound? Yes No

Treatment: ______________________________

____

Previous history of other wounds?

Yes No

Description of past wound: _________________________

____

Treatment of past wound: __________________________

____

____

Are you currently taking an anticoagulant? **Yes** **No**

Warfarin Xarelto

Other: ____

Past Medical and Social History

List all serious illnesses. (Example: Diabetes, Hypertension, Heart Disease).

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

List any personal past illness and/or surgeries

____

____

____

Allergies and reaction:

____

____

List any medications you are taking and the dosage

____

____

____

Do you smoke? Y N

Do you drink? Y N Socially

Height: _________ **Weight:**_________ **B/P:** _________ **Temp:** _________ **Pulse/Resp:**_________ **O2:**_________

Consent to Wound Care Treatment

Patient Name: ___________________________ Date of Birth: ________________________

Patient hereby voluntarily consents to wound care treatment by WCRX Health and its respective employees, agents and representatives. Patient understands that this Consent Form will be valid and remain in effect from the date of signature, as long as the Patient receives care, treatment and services by WCRX Health. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

1. **General Description of Wound Care Treatment:** Patient acknowledges that WCRX Health and/or its Wound Care Provider has explained that treatment by WCRX Health may include, but shall not be limited to: debridements, dressing changes, biopsies, physical examinations, diagnostic procedures, laboratory work, skin subs, and administration of medications. Patient acknowledges that WCRX Health and/or its Wound Care Provider has given Patient the opportunity to ask and have answered all questions regarding the treatments that may be provided by WCRX Health and its Wound Care Providers.
2. **Benefits of Wound Care Treatment:** Patient acknowledges that WCRX Health and/or its Wound Care Provider has explained that the benefits of wound care treatment include: enhanced wound healing and reduced risk of amputation and infection.
3. **Risks/Side Effects of Wound Care Treatments:** Patient acknowledges that WCRX Health and/or its Wound Care Provider has explained that wound care treatment may cause side effects and risks including, but not limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to surrounding tissues, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissues and prolonged healing or failure to heal.
4. **General Description of Wound Debridements:** Patient acknowledges that WCRX Health and/or its Wound Care Provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment by WCRX Health and/or its Wound Care Provider, multiple wound debridements may be medically necessary and will be performed by an authorized practitioner.
5. **Risks/Side Effects of Wound Debridement:** Patient acknowledges that WCRX Health and/or its Wound Care Provider has explained that the risks or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as nerves, allergic reactions to topical and skin prep solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal.

Patient specifically acknowledges that WCRX Health and/or its Wound Care Provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient and could also result in dissemination of bacterial and bacterial toxins into the bloodstream and thereby cause severe sepsis. Patient also acknowledges that WCRX Health and/or its Wound Care Provider has explained that debridement will make the wound larger due to the removal of necrotic (dead) tissue from the margin or boarders of the wound.

Consent to Wound Care Treatment, page 2

The patient hereby acknowledges that he or she has read and agrees to the contents in sections 1 through 5 of this document. Patient agrees that his or her medical condition has been explained to him or her by WCRX Health and/or its Wound Care Provider. Patient agrees that the risks, benefits, and alternatives of care provided by WCRX Health have been discussed with Patient. Patient has read this document or had it read to him/her and understands the contents herein. The Patient has had the opportunity to ask questions and has received answers to all of his or her questions.

The patient understands that WCRX Health will submit my insurance claims and that he or she will be responsible for any deductible, co-payments, co-insurance rendered for the services provided.

By signing below, Patient consents to the care, treatment, and services described in this document and orally by WCRX Health and/or its Wound Care Provider.

Signature of Patient: ____________________________________

Date: ________________Time:__________________Facility:__________________________

Signature of Parent/Conservator/Guardian: ____________________________________

Name of Parent/Conservator/Guardian: ____________________________________

Date: ________________Time:__________________

If signed by other than patient, indicate relationship: _____________________________

The undersigned Wound Care Provider has explained to the Patient (or his or her legal representative), in layman's terms, the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment procedure(s).

Signature of Wound Care Provider: ____

Date: _______________ Time:__________________

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