Texas Wound Solutions

Serving Dallas/FTW North Metroplex &
Houston Metroplex

Phone: 972-338-4070
Fax: 800-404-7725
Email: info@texaswoundsolutions.com

PATIENT DETAILS:

Date _____

Name: _____ DOB _____

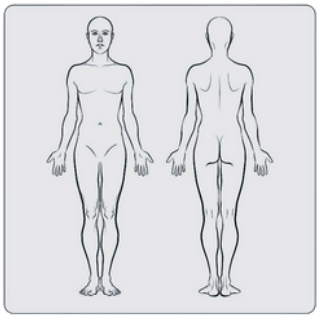
Address: _____

Insurance Provider: _____

Home Health Provider & Current Frequency (if applicable) _____

_____ POA Status _____

WOUND LOCATION



Please mark area associated with wound(s) location

Approximate date of onset of wound(s): REASON FOR REFERRAL:

- ☐ New wound
- ☐ Second opinion
- ☐ Needs debridement
- ☐ Difficulty transporting to clinic
- ☐ Other: _____

Current wound care team/hospital system for previous records:

_____

PRIOR TREATMENT/MANAGEMENT:

- ☐ Ankle-Brachial Index/Vascular Studies
- ☐ Negative Pressure Wound Therapy/ VAC
- ☐ Compression
- ☐ Debridement
- ☐ Dressing Type
- ☐ Offloading device
- ☐ Hyperbaric Oxygen
- ☐ Wound Biopsy
- ☐ Antibiotics
- ☐ Culture and Sensitivity

REFERRING CONTACT INFORMATION

Contact Name: _____ **Company:** _____

Contact Phone: _____ **Email:** _____

Fax: _____

Please complete form and email or fax.

Please attach a face sheet with any insurance information and any clinical notes, if applicable.