305-854-7377
305-975-7774
agonzalez@medsourcehealth.net
https://www.medsourcehealth.net

MED SOURCE CONSULTANTS
EMPOWERING HEALING WHERE YOU ARE: AT HOME WOUND CARE

# PATIENT CONSULT REQUEST FORM

**ALL ITEMS MARKED WITH (*) ARE REQUIRED.**

## REFERRING PROVIDER INFORMATION*

PERSON COMPLETING THIS FORM: NAME:_____ PHONE#: _____

PATIENT AWARE OF CONSULT REQUEST? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN:_____ PHONE #:_____ FAX #: _____

REFERRING PHYSICIAN (IF OTHER THAN PRIMARY): _____

REFERRING FACILITY NAME: _____

REFERRING FACILITY PHONE #:_____ REFERRING FACILITY E-MAIL ADDRESS: _____

IPA/MSO (IF APPLICABLE): _____

## PATIENT INFORMATION

IS THE PATIENT'S PCP AWARE THAT MEDSOURCE CONSULTANTS WILL BE CONTACTING THE PATIENT FOR TREATMENT?

□YES □ NO

PATIENT NAME*:_____ D.O.B. *:_____

PATIENT ADDRESS*:_____ CITY:_____ STATE:_____ ZIP:_____

PATIENT PHONE*:_____ PATIENT EMAIL: _____

CAREGIVER/FAMILY PHONE*:_____ CAREGIVER/FAMILY EMAIL: _____

CURRENT LOCATION OF PATIENT: _____

PATIENT LOCATION: □SNF/ALF □HOME

## ELIGIBLE INSURANCE INFORMATION*

DATE OF REFERRAL*:_____ MEDICARE NUMBER*: _____

NAME OF HEALTH PLAN:_____ PLAN TYPE: _____

MEMBER ID: _____

## REASON FOR REFERRAL

CPT CODE*: _____ WOUND LOCATION*: _____

WOUND TYPE: ☐ ARTERIAL ☐ DIABETIC ☐ PRESSURE ☐ SURGICAL ☐ TRAUMA ☐ VENOUS

☐ OTHER: _____

**Consult Request from PCP:** include patient face sheet/demographics and pertinent medical records.

**Consult Request from Home Health/ SNF:** include patient face sheet/demographics, patient skilled authorization number (if Part A), physician order and pertinent medical records.