| Iowa Mobile Medical | Iowa Mobile Wound Care Patient Intake Form | |
|---|---|---|
| | Questions:<br>888-774-2282 | Send Referrals to:<br>Email: Info@Iowamobilemedical.com<br>Or Fax: 515-630-0535 |

## Referring Partner

| | | |
|---|---|---|
| * Name | Phone | Email |
| * Referring Clinic/Agency | Phone | * Fax |
| Scheduling Contact | Scheduling email | Scheduling Fax |
| Scheduling Phone | Preferred method of contact for response:<br>Phone AND ☐ Email or ☐ Fax | |
| * PCP | PCP Phone | * PCP Fax |
| PCP Clinic: Address, City, State, Zip | | |

## PATIENT INFORMATION

| | | |
|---|---|---|
| * Patient Name | * Phone | * DOB |
| * Address, City, State, Zip | | |
| Power of Attorney | Phone | Email |

☐ Private Residence ☐ Assisted Living ☐ Skilled Nursing ☐ Group Home ☐ Long Term Care ☐ Other _____

Patient Aware of Referral to Iowa Mobile Medical? YES or NO (Circle one)

## INSURANCE INFORMATION – Please attach a copy of the patient's insurance cards

| | | |
|---|---|---|
| * Primary Insurance | * Member ID | Phone |
| Secondary Insurance | Member ID | Phone |

## WOUND 1– Please Describe

| | | |
|---|---|---|
| Type | Severity | Location |
| Previous treatment tried and failed | | |

## WOUND 2- Please Describe

| | | |
|---|---|---|
| Type | Severity | Location |
| Previous treatment tried and failed | | |

## Please send the information below with your referral. Once we receive the information, we will begin insurance approval process and scheduling the patient visits.

| | |
|---|---|
| ☐ Copy of Insurance cards | ☐ Photos of wound (if available) |
| ☐ Date of Referral: | ☐ Documentation of treatment |

**ATTENTION: CASE MANAGERS, DISCHARGE PLANNERS, REFERRAL COORDINATORS AND UTILIZATION MANAGERS**

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