REFERRAL FOR WOUND CARE

OFFERING MOBILE SERVICES
BECAUSE WOUND CARE
SHOULD BE AVAILABLE TO EVERYONE

Western Slope
MOBILE WOUND CARE

PATIENT INFORMATION

Patient Name _____ DOB _____

Where is the patient located? ☐Home ☐ Facility _____ Facility Name

Street Address _____ City, State _____

Contact Name (if different than patient) _____ Contact Number _____

Insurance _____ ID Number _____

Please attach patient face sheet, if possible.

WOUND INFORMATION

Type of wound: (please circle)

Pressure / Arterial / Venous / Infection / Burn / Trauma / Surgical / Diabetic Ulcer / Skin tear
Moisture Associated Dermatitis / Deep Tissue Injury

Other _____ ☐ Unsure ☐ Date Wound Notice:_____

Previous treatment(s)/ Additional information/ Notes: _____

UPON COMPLETION Fax to: 970-399-9897

Questions? Contact Us
Phone: 970-399-9899
www.wsmwoundcare.com