VASCULAR INSTITUTE
OF CHATTANOOGA

Wound Care Referral Pad

p 423-602-2750 f 423-602-2762

Date: _____

Patient Name: _____ DOB: _____ Patient Phone: _____

Referring Provider Name: _____

Phone # _____ Fax # _____

Referring Practice Address _____

HISTORY & PHYSICAL EXAM

TYPE OF WOUNDS (check all that apply)

_____Acute
_____Chronic
_____Arterial
_____Venous
_____Diabetic
_____Traumatic
_____Surgical
_____Pressure Sores
_____Radiation
_____Pilonidal Cyst
_____Hidradenitis Suppurativa
_____Atypical
_____Charcot Foot
_____Other_____

WOUND DESCRIPTION

Size: _____

Wound Duration: _____ Location: _____

Current Treatment, if any: _____ Any Imaging / US Performed?: _____

_____ If so, where?: _____

Provider's Signature _____ **Date:** _____

Please fax demographic and any relevant records and studies you have for this patient.
Vascular Institute of Chattanooga - f: 423.602.2762

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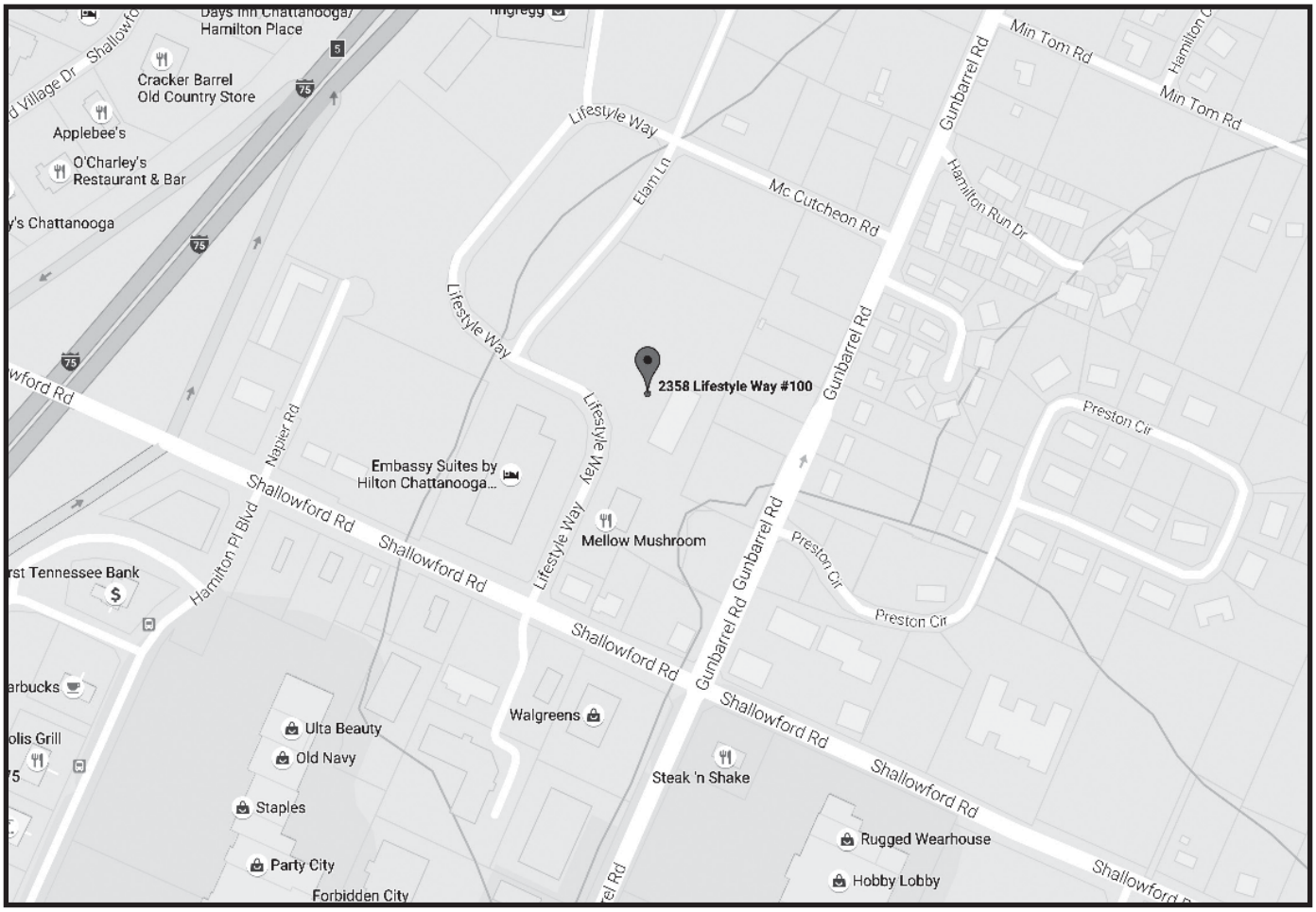

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