NEWCare
New England Wound & Ostomy Care
Phone: 413-475-3233
Fax: 413-475-3249

WOUND CARE REFERRAL REQUEST

Patient Information

Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (home) _____ **(cell)** _____ **(work)** _____

Social Security Number: _____ **Interpreter Needed?:** ☐ **Yes** ☐ **No**

Primary Insurance: _____ **Subscriber ID:** _____

Secondary Insurance: _____ **Subscriber ID:** _____

Primary Care Physician (PCP): _____

PCP Phone: _____ **PCP Fax:** _____

Does patient require Hoyer Lift?: ☐ **Yes** ☐ **No**

Does patient have a Guardian or Health Care Proxy? ☐ **Yes** ☐ **No**

Responsible Party: ☐ **Patient** ☐ **Other:** _____

Wound Information

Location of Wound(s): _____

Surgical Wound?: ☐ **Yes** ☐ **No** **If Yes, Date of Surgery:** _____

Please select all comorbidities that apply: ☐ **PVD** ☐ **Venous Insufficiency/Stasis** ☐ **Cardiovascular Disease**

☐ **Diabetes** ☐ **Obesity** ☐ **Immobility** ☐ **Immunocompromised** ☐ **Neuropathy** ☐ **Chronic Renal Failure**

Requested Visit Information

☐ **Standard Referral** ☐ **Urgent Referral**

Has patient been seen today in any other medical facility? ☐ **Yes** ☐ **No**

Referral Reason(s): _____

Referred By: _____

Phone: _____ **Fax:** _____

Preferred Office: ☐ **Amherst** ☐ **Easthampton** ☐ **Florence** ☐ **Greenfield** ☐ **Westfield**

Please provide a copy of patient demographics, recent office and/or hospital notes and any recent vascular ultrasounds if available. Information can be faxed to **413-475-3249**.