Referral Form

STAY HOME WOUND CARE

Delivering expert wound care right where you need it most - at home.

Referring Provider/Agency: _____ **Fax:** _____-_____-_____

Patient Name: _____ **DOB:** _____/_____/_____

Patient Phone: _____-_____-_____ **Patient Sex:** ☐ **M** / ☐ **F** **Patient Location:** ☐ **Home** ☐ **Facility**

If facility, what's the facility name? _____

Patient Location Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Care Physician Name: _____**Fax:** _____-_____-_____

POA/Caregiver Involved: Y / N If yes, name & contact: _____

Emergency Contact (if different from above): _____

Wound Location: _____ **Approximate Size:** _____**cm x**_____ **cm x** _____**cm**

Onset Date of Wound (best approximation): _____/_____/_____ **Wound Diagnosis:** _____

Previous Treatments: _____

Primary Insurance: ☐ **Medicare** ☐ **Medicare Advantage** ☐ **Commercial** ☐ **VA** ☐ **Other** _____

Home Health Agency (if different from referral source): _____

Phone: _____-_____-_____ **Email:** _____

Home Health Case Manager: _____

Home Health Treating RN: _____

Phone: _____-_____-_____ **Email:** _____

Please be sure to also include the following:

- ❑ Facesheet with insurance information
- ❑ Records of prior treatment of current wounds
- ❑ Medication list, if possible
- ❑ Photos of the wounds, if possible

Next Steps:

1. Fax or email referral to: 248-878-2363 support@stayhomewound.com
2. We will email or call you to confirm it's been received.
3. We will contact the patient to schedule.