Houston Methodist Wound Care Program

Referral Form

Phone: 713.441.2235 Fax: 346.238.0122

6550 Fannin Street, Suite 657 • Houston, TX 77030

HMHWoundCare@houstonmethodist.org

HMH2297

REFERRING PHYSICIAN		
Physician Name:	Phone:	Fax:

SERVICES REQUESTED
[ ] Wound care evaluation/treatment
Diagnosis

PATIENT HISTORY	
Patient Name:	Daytime Phone:
DOB:	Cell Phone:
Wound Location:	Current Wound Care:
Wound Acquired:	Does Patient have Diabetes?

WOUND TREATMENT HISTORY			
[ ] Surgical Debridement	Date:	[ ] Skin Graft	Date:
[ ] Revascularization	Date:	[ ] Antibiotics	Date:
[ ] Offloading	Date:	[ ] Amputation	Date:

PLEASE FAX OR SEND ANY OF THE FOLLOWING INFORMATION:

- PATIENT DEMOGRAPHICS
- PATIENT ID
- INSURANCE CARD
- HISTORY AND PHYSICAL
- PATHOLOGY REPORT
- EKG
- OPERATIVE REPORT
- CULTURES
- LABS (CBC / CMP / SED RATE / HGB A1C / ALBUMIN)
- RADIOLOGY (X-RAY / BONE SCAN / CHEST X-RAY / MRI)
- LIST OF MEDICATIONS / ALLERGIES
- WOUND CARE NOTES

PLEASE INSTRUCT THE PATIENT ON THE FOLLOWING:

- To bring all medications or a list of medications to their appointment
- To bring insurance cards and any other payor information
- To bring any medical records, as requested above
- The evaluation will take approximately 2 hours / Arrive 15 minutes early in order to complete the registration process
- If patient is too debilitated to sign authorization permits, please instruct a family member, preferably one with power of attorney, to accompany patient

Please indicate how you would like to receive an update of your patient's evaluation/treatment.

Phone: _____ Fax: _____ Email: _____

Physician's Name | Phone #

Date/Time | Physician's Signature

(We cannot accept stamped signatures)