



Please print clearly. Attach the signed order, recent visit notes or H&P, medication list, and a copy of the insurance card (front and back). Our care coordinator verifies insurance, requests any prior authorization, and calls you within one business day.

Date sent _____

Priority: ☐ Routine ☐ Urgent - needs prompt attention**1. REFERRAL SOURCE**

Your name _____

Organization / practice _____

Phone _____

Fax _____

Email _____

Source: ☐ Physician / NP / PA office ☐ Hospital / discharge planner ☐ SNF / rehab ☐ Case manager ☐ Social worker
☐ Family / caregiver ☐ Patient ☐ Other

2. SERVICES REQUESTED

Wound type: ☐ Surgical / incision ☐ Dehisced surgical ☐ Pressure injury ☐ Diabetic foot ulcer ☐ Venous ulcer ☐ Arterial ulcer
☐ Skin tear / trauma ☐ Other

Number of wounds _____

Wound location(s) _____

When did the wound start? _____

Pressure injury stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Unstageable ☐ Deep tissue injury ☐ N/A

Latest measurements, if known (L x W x D in cm, and date measured) _____

Negative pressure wound therapy (NPWT)? ☐ Yes - already in place ☐ Yes - needs to start ☐ No

NPWT device and supplier (if any) _____

Requested visit frequency (e.g. 3 visits a week for 4 weeks) _____

Current dressing orders (cleanser, primary and secondary dressing, and how often) _____

3. PATIENT

Last name _____

First name _____

Date of birth _____

Phone _____

Sex (as listed on insurance): ☐ Female ☐ Male ☐ X / unspecified

Street address _____

Apt / suite _____

City _____

ZIP _____

County: ☐ King ☐ Snohomish ☐ Pierce ☐ Kitsap ☐ Other: _____

Preferred language _____

Caregiver / emergency contact (name and phone) _____

4. INSURANCE (ATTACH A COPY OF THE CARD, FRONT AND BACK)

Primary insurance plan _____

Member ID _____

Group # _____

Subscriber name (if not the patient) _____

Subscriber date of birth _____

Relationship to patient _____



Secondary insurance (if any)

Secondary member ID

5. ORDERING PROVIDER

Provider name

NPI

Date provider last saw the patient

Practice phone

Practice fax

Practice address

Signed order: ☐ Attached ☐ Please request it from the provider**6. CLINICAL INFORMATION**

Primary diagnosis

ICD-10 code(s)

Hospital / facility discharge date (recent or expected)

Hospital / facility name

Homebound? ☐ Yes - leaving home takes considerable effort ☐ No ☐ Not sure

Why is leaving home hard? (e.g. needs walker and help of 1 person; short of breath after 20 feet)

Getting home health from another agency now? ☐ Yes ☐ No ☐ Not sure**Diabetes?** ☐ Yes ☐ No ☐ Unknown

Wound clinic or surgeon following the patient

Clinical notes - anything our clinician should know before the first visit

7. WHEN IS CARE NEEDED?

Earliest start date

Preferred visit days / times

8. DOCUMENTS ATTACHED☐ Signed order ☐ Recent visit notes or H&P ☐ Discharge summary ☐ Medication list ☐ Insurance card ☐ Wound photos

Referring person signature

Date