KEARNEY COUNTY HEALTH SERVICES
Wound Care

KCHS Wound Care
p 308.832.6535 | f 888.835.6946
Referral Email: Referrals@RestorixHealth.com
727 East 1st Street, Minden, NE 68959

WOUND CARE REFERRAL FORM

PATIENT DEMOGRAPHICS *(may attach face sheet instead)*

Today's Date:		Patient DOB:	
Patient Name:		☐M ☐F	
Primary Care Physician:		Phone:	
Address:	City:	State:	Zip:
Phone:	Alternate Phone:		

PATIENT INSURANCE INFORMATION *(may attach face sheet instead)*

Primary:		ID#:	Group#:
Phone:			
Secondary:		ID#:	Group#:
Phone:			
Is patient in a nursing home?	☐ No ☐ Yes	Facility name:	
Is patient receiving home health care?	☐ No ☐ Yes	Agency name:	
Auto or workers' compensation claim?	☐ No ☐ Yes	Date of injury:	
Is patient in the hospital?	☐ No ☐ Yes Room No.	Is this a swing bed?	☐ No ☐ Yes

REFERRAL REASON

	Wound Location		***Wound Location***
☐ Arterial/ischemic ulcer		☐ Compromised skin graft or flap	
☐ Diabetic foot ulcer		☐ Crush injury	
☐ Pressure injuries/ulcer		☐ Non-healing, post-surgical wound	
☐ Venous ulcer		☐ Traumatic wound	
☐ Post-radiation ulcer/wound		☐ Other	

ADDITIONAL COMMENTS:

Is patient on antibiotics?	☐ No ☐ Yes	RX name:	
Is patient on blood thinners?	☐ No ☐ Yes	RX name:	

REFERRER INFORMATION

Referral Source:	☐ Physician	☐ Discharge Planner	☐ Nursing Home	☐ Nurse Practitioner
	☐ Home Health	☐ PA	☐ Other:	

Referrer Name:	Phone:	Fax:
Referral Office Contact:	Phone:	Ext:

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.