Goshen Health

Goshen Wound Center
2006 S Main St Suite B
Goshen, Indiana 46526
(574) 364-4560

Hours of Operation Monday - Friday 8 am - 5 pm
To Schedule Please Call (574) 364-4560
Fax Order To (574) 364-4561

Appointment Date and Time: _____

Patient Name _____
Date of Birth _____Social Security # _____
Address _____
City _____ State _____ Zip _____
Telephone # _____

Primary Insurance _____
Primary Policy # _____ Group # _____

Secondary Insurance _____
Secondary Policy # _____ Group # _____

Ordering Physician Signature _____
Ordering Physician _____

Primary Care Physician_____
Send Copy To _____
Fax Results To _____

Diagnosis #1 _____ ICD-10 Code _____
Diagnosis #2 _____ ICD-10 Code _____
Diagnosis #3 _____ ICD-10 Code _____
Diagnosis #4 _____ ICD-10 Code _____

FAX REFERRAL FORM

Today's date: _____

Does the patient have an open wound? ❑ Yes ❑ No

Is the patient an inpatient in a Skilled Nursing Facility? ❑ Yes ❑ No

If yes, is the patient under a Part A Medicare stay? ❑ Yes ❑ No

Wound #1	Wound #2
❑ Right Leg	❑ Right Leg
❑ Left Leg	❑ Left Leg
❑ Right Foot	❑ Right Foot
❑ Left Foot	❑ Left Foot
❑ Coccyx / Sacrum	❑ Coccyx / Sacrum

❑ Other (specify): _____

Please send a copy of patient's History and Physical, a recent Progress Note, most recent Labs, Vascular Studies, X-ray/imaging, current problems and Medication List, a current Face Sheet, and Insurance Card when faxing referral.
Thank you.

FOR OFFICE USE ONLY

Appointment Date: _____

Appointment Time: _____

Confirmation Call Made: _____