HealthCare

☐ University of Kentucky Hospital A.B. Chandler Medical Center
☐ UK HealthCare Good Samaritan Hospital
☐ UK HealthCare Ambulatory Services
☐ UK Dental and Oral Heatlh Clinics

COMPREHENSIVE VASCULAR CLINIC
NEW PATIENT REFERRAL FORM

(Patient Label Here)

Comprehensive Vascular Clinic
740 S. Limestone
Phone: 859-218-6388
Fax: 859-323-7755

Patient must have an open wound to be appropriate for referral. Medical Record #: _____

Patient Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: _____ Phone: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

	Yes	No
Is patient diabetic?	☐	☐
Is patient oriented?	☐	☐
Is patient ambulatory?	☐	☐
Is patient being brought by EMS?	☐	☐
Is patient from facility?	☐	☐

Does patient have home health? _____

If yes, Name & Phone of Home Health

_____
Name of Home Health Agency/Provider

_____
Home Health Phone Number

If yes, Name and Phone of Facility _____ _____
Home Health Phone Number Facility Phone Number

Does patient use: ☐ Wheelchair ☐ Walker ☐ Stretcher Interpreter needed? ☐ Yes ☐ No

How does the patient transfer? _____

Diagnosis: ☐ Pressure Ulcer ☐ Ischemic Wound ☐ Surgical Wound ☐ Traumatic Wound
☐ Diabetic Ulcer ☐ Wound Flap ☐ Venous ☐ Burn
☐ Other: _____

Location / Comments: _____

_____

Referring Provider: _____ _____
(Provider Name) (Provider Phone Number)

_____ _____
Referring Provider's Signature: Date / Time:

Contact: _____ Phone: _____