



**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**

- Right Leg
- Left Leg
- Right Foot
- Left Foot
- Coccyx / Sacrum
- Other (specify): \_\_\_\_\_

**Wound #2**

- Right Leg
- Left Leg
- Right Foot
- Left Foot
- Coccyx / Sacrum

**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: \_\_\_\_\_