UNIVERSITY of MARYLAND
UPPER CHESAPEAKE MEDICAL CENTER

Center for Wound Care
510 Upper Chesapeake Drive, Ste. 409
Bel Air, MD 21014
Phone: (443) 643-3500
Fax: (443) 643-3515

PHYSICIAN REFERRAL FORM

PATIENT INFORMATION:

Name: _____ Birth Date: _____ Sex: ☐M ☐F

Address: _____ Apt#:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____

Onset: _____ Is this a surgical wound? ☐ No ☐ Yes

Wound Site: _____ Is this an MVA related injury? ☐ No ☐ Yes

ICD-10 Codes: _____ Is this a work related injury? ☐ No ☐ Yes

Diabetic? ☐ Yes ☐ No Is this a non-work related injury? ☐ No ☐ Yes

SERVICE REQUESTED:

☐ Wound Care Consultation & Treatment

☐ Ostomy/Continence Consultation

☐ KCI V.A.C. Therapy for wounds

SUPPORTING DOCUMENTATION: (Please fax the following.)

☐ Current history and physical

☐ List of current medications, dressings, wound care, etc.

☐ Recent lab results and radiology reports

☐ Patient demographics and insurance information

Physician Name (Printed): _____ NPI: _____

Physician Signature: _____ Date: _____