Kindred Sugarland Hospital
Outpatient Wound Care Referral Form
SEND COMPLETED FORM TO: Fax (281) 275-6077

Referring Physician/Practitioner: _____
Phone no. _____ **Fax no:** _____

Best way to communicate patient's progress:
___ Phone ___ Fax ___ Letter ___ Other: _____

Patient's Name: _____
Date of Birth: _____
***Contact Phone(s):**(1)_____(2)_____
PLEASE VERIFY* *THAT PATIENT CONTACT INFORMATION IS **CURRENT & ACCURATE *TO HELP US AVOID DELAYS IN AUTHORIZATION & SCHEDULING.*

Reason for referral: ___**Wound Care**
(WC Dx: _____)
___**Hyperbaric Oxygen Evaluation / Treatments**
(HBO Dx: _____)
___**Other:** _____

Please fax the following important information:

- ☐ **Patient Demographic Data/Payor Source(Facesheet)**
- ☐ **Physician/Practitioner Orders for Referral**
- ☐ **Recent History and Physical**
- ☐ **Current Medication List & Allergies**
- ☐ **Diagnostic Results (X-Rays, Vascular Studies/Dopplers)**
- ☐ **Recent Labs and Cultures**
- ☐ **Physician/Practitioner Progress notes/HBO Evaluation Note(*if available*)**

Fax: (281) 275-6077 | Tel: (281) 275-6033

For *clinical* support/questions, call: (281) 275-6097

1550 First Colony Blvd., Sugarland, Texas 77479