PRESBYTERIAN

Wound Center Consult Request

Please complete this form in full and fax to (505) 823-8875. **Please note:** To accurately triage and treat the patient, please complete all parts of this form.

Provider Contact Information

Provider Name:	**Phone:**	**Fax:**

Patient Demographics

Patient Name:	**DOB:**
Phone Number:	**Alternate Contact:**
Insurance Company & Policy #:	
Is the patient able to give legal consent for treatment? ☐ **Yes** ☐ **No, contact info:**	
Does the patient reside in a facility? ☐ **No** ☐ **Yes, contact info:**	
Does the patient have home healthcare? ☐ **No** ☐ **Yes, contact info:**	

Wound Information

	Location	Description
1		
2		
3		
Has the patient been given antibiotics? ☐ **No** ☐ **Yes** (describe)**:**		
Current Wound Care:		
Tests/treatments ordered/done:		
Specific concerns or special considerations:		

Please mark applicable boxes below:

- ☐ Last office visit note pertaining to the reason for consult included
- ☐ Comprehensive problem list included (if not on the last visit note)
- ☐ Current medication list included (if not on the last visit note)
- ☐ Diagnostic test results included
- ☐ Wound Center information sheet given to patient

Provider Order

☐ **Presbyterian Wound Program to evaluate and treat wound**

Diagnosis/Etiology:

Provider Signature: **Date:**

PRESBYTERIAN

Presbyterian Wound Center Ostomy Consult Request

Please complete this form in full and fax to (505) 823-8875. **Please note:** To accurately triage and treat the patient, please complete all parts of this form.

Provider Contact Information

Provider Name:	**Phone:**	**Fax:**

Patient Demographics

Patient Name:	**DOB:**
Phone Number:	**Alternate Contact:**
Insurance Company & Policy #:	
Is the patient able to give legal consent for treatment? ☐ **Yes** ☐ **No, contact info:**	
Does the patient reside in a facility? ☐ **No** ☐ **Yes, contact info:**	
Does the patient have home healthcare? ☐ **No** ☐ **Yes, contact info:**	

Ostomy Information

☐ **Pre-operative**	☐ **Post-operative**
Surgery Date:	**Type of ostomy:**
Surgical procedure:	☐ **Permanent** ☐ **Temporary; how long:**
Type of ostomy expected:	**What are the concerns?**
☐ **Permanent** ☐ **Temporary** ☐ **Unknown**	
Special considerations:	

☐ Last office visit note pertaining to the reason for consult included

☐ Comprehensive problem list included (if not on the last visit note)

☐ Current medication list included (if not on the last visit note)

☐ Wound Center information sheet given to patient

Provider Order

☐ **Presbyterian Wound Program to evaluate and treat ostomy:** pre-operative visits will include site marking if surgery is scheduled

Diagnosis/Etiology:

Provider Signature: **Date:**