Wound Edge Medical Referral Form

2279 Coney Island Ave 2nd Floor, Wound Care Wing, Brooklyn, NY 11223
Phone: 347-669-3535
info@woundedgemedical.com | www.woundedgemedical.com

Patient Name:	D.O.B:	Telephone #:	
Address:	City:	State:	Zip:
Referring Physician:	Pediatrist (please circle) : Yes No		
Telephone #:	Fax #:		

Diagnosis:	☐ Arterial ☐ Diabetic Ulcers ☐ Ischemic Ulcers ☐ Neuropathic Ulcers ☐ Venous Insufficiency ☐ Traumatic Wounds ☐ Surgical Wounds ☐ Burns ☐ Vasculitis ☐ Radiation Wounds ☐ Other Chronic, Non-Healing Wounds

Please send the following if available to expedite care:

1. Past H&P
2. Current Labs and X-Rays
3. Insurance
4. Medication List
5. Face Sheet if Applicable

_____ _____

Physician Signature Date

Please email to info@woundedgemedical.com