HAWAI'I
ADVANCED WOUND CARE

P: (808) 289-7011
F: (808) 796-5303
W: www.hiwound.com
E: info@hiwound.com

SEND REFERRALS TO:
info@hiwound.com
Fax: (808) 796-5303

PATIENT REFERRAL FORM

ALL ITEMS MARKED WITH (*) ARE REQUIRED.

REFERRING PROVIDER INFORMATION

NAME OF PERSON COMPLETING THIS FORM: PHONE #:

PATIENT AWARE OF REFERRAL TO HAWAII ADVANCED WOUND CARE?* ☐ YES ☐ NO

PRIMARY REFERRING PHYSICIAN*: REFERRING NPI*:

REFERRING FACILITY PHONE#*: REFERRING FACILITY E-MAIL:

PATIENT'S PCP (IF OTHER THAN REFERRING PROVIDER):

PATIENT INFORMATION

PATIENT NAME*: D.O.B*:

PATIENT ADDRESS:* CITY: STATE: ZIP:

PATIENT PHONE:* PATIENT EMAIL:

ELIGIBLE INSURANCE INFORMATION

PRIMARY INSURANCE *: MEMBER ID*:

SECONDARY INSURANCE : MEMBER ID:

TERTIARY INSURANCE: MEMBER ID:

REASON FOR REFERRAL

ICD-10 CODE*: WOUND LOCATION*:

WOUND TYPE: ☐ ARTERIAL ☐ DIABETIC ☐ PRESSURE ☐ SURGICAL ☐ TRAUMA ☐ VENOUS ☐ UNKNOWN

OTHER:

Has the wound received at least 30 days of documented conservative treatment?* ☐ YES ☐ NO ☐ UNKNOWN

SUPORTING RECORDS

To help prevent delays in scheduling the patient's evaluation and treatment, please include the following records and documentation, if available, when submitting this referral form:

Patient facesheet/demographics:	☐ ATTACHED	☐ NOT AVAILABLE
Copy of all active insurance card (front & Back):	☐ ATTACHED	☐ NOT AVAILABLE
For HMO patient, attached copy of referal submit to the insurance*:	☐ ATTACHED	☐ NOT AVAILABLE
Patient's pertinent medical records*:	☐ ATTACHED	☐ NOT AVAILABLE
Patient's medication list:	☐ ATTACHED	☐ NOT AVAILABLE
Patient's imaging of applicable:	☐ ATTACHED	☐ NOT AVAILABLE
Patient's labs within the past 3 months (A1c if diabetic):	☐ ATTACHED	☐ NOT AVAILABLE