Name: _____ Gender: ❑ Male ❑ Female

Address: _____

Phone #: _____ Date of Birth: _____

Emergency Contact: _____ Phone Number: _____

Allergies: _____

DPOA/Guardian: _____ Phone Number: _____

PCP: _____ Phone Number: _____ Fax Number: _____

Referring MD: _____ Phone Number: _____ Fax Number: _____

Primary Insurance: _____ Secondary Insurance: _____

Insurance #: _____ Insurance #: _____

Ins. Phone #: _____ Fax #: _____ Ins. Phone #: _____ Fax #: _____

❑ Pre−authorized 20 Visits: ❑ Yes ❑ No Contact Name: _____

Diagnosis: _____ Location of Wound: _____

Onset: _____ Current Dressing: _____

Previous Vascular Studies: ❑ Yes ❑ No ❑ Unknown Previous X−rays or Films: ❑ Yes ❑ No ❑ Unknown

Previous Patient WHI: ❑ Yes ❑ No If YES, by whom: _____

Alert and Oriented ❑ Yes ❑ No Able to Sign Consent: ❑ Yes ❑ No Able to be Left Alone: ❑ Yes ❑ No

Currently being seen by VNA services: ❑ Yes ❑ No If YES, name and phone #: _____

Wheelchair bound: ❑ Yes ❑ No Ambulatory: ❑ Yes ❑ No Bed: ❑ Yes ❑ No Hoyer: ❑ Yes ❑ No

CareVan: ❑ Yes ❑ No Comments: _____

Preferred Language: _____

Communication Needs and Device Needed:

❑ Hearing _____

❑ Visual _____

❑ Speech _____

Referral Contact Name: _____ Phone Number: _____

WHI Contact Name: _____ Date: _____

Appointment Date/Time: _____ **WHI MD:** _____

Wentworth−Douglass Hospital
WOUND HEALING INSTITUTE
INTAKE/NEW REFERRALS

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Rev. 08/09/11