Wound Care Referral Form

John C. Harris Wound Healing Center
688 Medical Center Dr. E., Suite 101
Clovis, CA 93611
P: 559.324.6820 | **F**: 559.324.6823
www.cloviswoundhealing.org
NPI: 1316027709

Patient Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ ZIP: _____

Phone: Primary _____ Secondary _____ Emergency _____

Insurance

Primary: _____ Secondary: _____

Wound Type

☐ *Diabetic Foot Ulcer*
☐ *Venous Stasis Ulcer*
☐ *Arterial Ulcer*
☐ *Pressure Injury*
☐ *Non-Healing Surgical Wound*
☐ *Traumatic Wound*
☐ *Wound from Radiation Injury*
☐ *Other:* _____

Wound Location: _____ Duration: _____

Please send a copy of insurance cards, demographics, recent progress notes, recent H&P, wound measurements and any recent diagnostic studies if applicable.

Authorization is required for Sante, First Choice, TriWest, Health Comp, PACE, & Work Comp. Authorization must be requested by the referring provider *PRIOR* to scheduling an appointment. Please request the following CPT codes:

- **99205 x 1**
- **99215 x 10**
- **11047 x 10**

Authorization must include Authorization Number and all CPT codes/quantities listed above.

ICD-10 Code & Diagnosis: _____

Primary Care MD: _____ Cardiologist or Specialist: _____

Referring Physician: _____ Signature: _____

Office Contact Person: _____ Phone: _____ Fax: _____

OFFICE USE ONLY:

☐ Referral not completed
☐ Insurance requires prior-authorization
☐ Clinic does not treat referring diagnosis
☐ Clinic is NOT Contracted with patient's assigned medical group
☐ Please redirect request to patient medical group.