



Phone: 561-598-9609

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Leesang Services
Wound Care Services
Your Recovery, Our Priority

Referral Form

Patient: _____
First Name Last Name

D.O.B.: ____/____/____

Social Security Number: _____

Patient Phone Number: _____ Type of Insurance: _____

Referring Facility Name: _____

Facility Fax: _____ Facility Phone: _____

Wound Type? _____

Wound Location? _____

(arm, head, leg, hand, foot, chest, back, abdomen etc.).

Referral Diagnosis Description / Code: _____

Please submit the following available documents with referral:

- Demographics
- Copy of Insurance Card
- Copy of Photo ID
- Current Medication List
- Diagnosis List
- Wound information (including assessment, orders, treatments provided)
- Diagnostic Imaging (X-Ray, MRI)
- Vascular Studies
- Recent Labs (Including HGBA1C if Diabetic)
- Culture Results
- Last 4 Office Visits

Comments:

