SPECIALTY WOUND CARE RAPID REFERRAL FORM

CLINIC 5Ĉ
WELCOME TO THE NEXT LEVEL

WoundCare@clinic5c.com
Fax: 509-381-3540
Phone: 509-606-1666

Patient Information

Name _____ DOB _____

Phone _____ Address _____

City _____ State _____ Zip _____

Primary Care Provider _____

Home Health Agency _____

Insurance Information:

Primary Insurance _____

Member ID / Policy # _____

Secondary Insurance _____

Member ID / Policy # _____

Wound Information:

New Wound: ☐ Yes ☐ No Previous Wound Care: ☐ Yes ☐ No

Current/previous provider treating wound _____

Wound Size _____ Wound Location _____

Wound Duration _____

Fax this form to: 509-381-3540 with the following:

- ☐ Health Insurance Card(s)
- ☐ Demographics Sheet
- ☐ Most recent wound photo(s) in color showing size of wound
- ☐ All chart notes pertaining to wound care
- ☐ Past pictures of wound (if available)

Care Coordinator Name _____ Date _____

Email _____ Phone _____ Fax _____