RESTORE FIRST HEALTH

Chronic Wound Allograft Referral

Referral Source _____ Contact _____ Phone _____

Current Home Care/Nursing Home Manager _____

Patient Information *(*required field)*

*Patient Full Name _____

*DOB _____ *Medicare#/MBI _____ SSN_____

*Address (of care provision) _____

*Emergency Contact _____ *Phone_____

*Primary Reason for Referral _____

_____

*Healthcare practitioner who will oversee wound care services_____

Orders

○ **Wound Care Allograft treatment**

Criteria:

- Wound MUST be 1cm x1cm or larger
- Open wound
- Not infected
- Chronic wound that has failed at least 4+ weeks of conventional treatment

Other services offered in office from Restore First Health:

○ **PIR Therapy (Diabetes & Metabolic Disorders)**

○ **Knee Pain Therapy (non-surgical; non-invasive injections)**

Additional orders or information about the patient you would like us to know in order to provide excellent care.

Healthcare Practitioner signature and credentials _____

Print name _____ Date _____

Requested Information: Please include these documents to ensure a safe patient transition

- Recent clinical notes, H&P, labs
- Current Medication List
- Most recent assessment of wound/primary reason for referral
- Dimensions of wound

Please submit your completed form by email (wound@restorefirsthealth.com) or FAX (470-201-2473).