DIVINE WOUND SPECIALIST

Address: 250 N Main Street, Suite 11K, Crown Point IN 46307 | Phone: (219) 257-2252

FAX TO: (219)-377-7300 | EMAIL: divinewoundspecialist@gmail.com

SECTION 1: REFERRING PROVIDER DETAILS

Facility/Practice Name: _____ **Contact Person:** _____

Direct Phone: _____ **Fax Number:** _____

Provider NPI Number: _____

SECTION 2: PATIENT DEMOGRAPHICS

Name: _____ **DOB:** _____ **Gender:** _____

Patient Phone: _____

Current Location *(Address, Facility Name, or Room/Wing #)*:

_____

SECTION 3: INSURANCE INFORMATION

Insurance Name: _____ **Policy / Member ID:** _____

Secondary Insurance Name: _____ **Secondary ID / Group #:** _____

SECTION 4: WOUND TYPE (Check all that apply)

☐ Pressure Injury (Stage: ____) ☐ Diabetic Foot Ulcer ☐ Venous Leg Ulcer

☐ Surgical / Non-Healing Wound ☐ Arterial Ulcer ☐ Other: _____

REQUIRED ATTACHMENTS (PLEASE INCLUDE WITH FAX OR EMAIL)

☐ **Patient Face Sheet / Demographics** ☐ **Front & Back of Insurance Card(s)**

☐ **Latest Clinical Progress Notes & Wound Logs**

SECTION 5: HIPAA ATTESTATION & SIGNATURE

Notice: This transmission is designed to share Protected Health Information (PHI) in accordance with HIPAA. Information collected is strictly for clinical intake, treatment planning, and care coordination by Premier Wound Care.

☐ **Attestation of Patient Consent (Required):** I certify that I am an authorized healthcare provider or representative of the referring entity. I confirm that the patient (or their legal representative) has been informed of this referral to Premier Wound Care and has authorized the release of their medical records to initiate mobile wound care services.

Authorized Person's Initial: _____ **Date:** _____

Printed Name & Title: _____