



WOUND SERVICES REFERRAL
Sparrow Wound Center
1322 E. Michigan Ave., Suite 204
Medical Arts Building
Lansing, MI 48909

Phone: (517) 364-3504 Fax: (517) 484-3337

First appointment: Date: _____ Time: _____

Date of referral: _____ Person taking referral: _____

Patient Information: Name: _____

DOB: _____ Parent/Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Extended Care Facility: _____ phone: _____ fax: _____

Ambulatory: Y N W/C: Y N Stretcher: Y N DPOA: Y N

Wound Information:

Date of Injury/Wound _____ Wound Type _____

Wound Location _____

Wound Infection Known or Suspected: Y N MRSA: Y N VRE: Y N

Comments/Special Needs _____

Current treatment: _____

Physician Information:

Primary Care Physician _____

Phone _____ Fax# _____

Referring Physician _____

Phone _____ Fax _____

Wound Care Physician _____

Phone# _____ Fax# _____

Physician: _____

Phone# _____ Fax# _____

Home Care Yes No Home Care Agency _____

Phone# _____ Fax# _____

Insurance Information:

Primary Insurance _____ Secondary Insurance _____

Insured Authorization# _____

Date Ends _____ and/or numbers of visits _____

Please fax this information to the Wound Center:

Dopplers _____ History& Physical _____ Med List _____ Most recent Progress Note _____