McLaren
GREATER LANSING
Wound Care & Hyperbaric Center
2727 S. Pennsylvania Avenue Lansing, MI 48910
Phone: (517) 975-1500 Fax: (517) 975-1514

It's easy to refer a patient to the Wound Center, just…

1. Complete this form and fax to: **517-975-1514.**
2. The Wound Center will contact the patient to schedule an appointment.

*If insurance prior authorization is required, please provide the authorization # with the referral. Appointment will be scheduled upon receipt of authorization.

3. The referring physician will receive confirmation of the scheduled appointment.

Date of referral:_____ Name of contact for referral:_____
Referral from:
☐Physician office ☐Hospital ☐Emergency Dept ☐Home Care ☐Patient
☐Nursing Home _____ Ph:_____
***Nursing home patient must be accompanied by caregiver.**

Patient Information:
Name:_____ DOB:_____
Parent/Guardian:_____ Address:_____
Phone: Home;_____ _____
Work/Cell: _____ _____
Patient is: ☐ambulatory ☐uses wheelchair ☐needs Hoyer lift to transfer

Wound Information:
Location:_____ Wound Type:_____
How long wound present?_____ Wound Infection: ☐Yes ☐ No ☐?
Wound cultures done: ☐Yes ☐ No Date:_____ Copy of results: ☐Yes ☐ No
Current Wound Treatment:_____

Is patient diabetic? ☐Yes ☐No If yes, what is HbA1c_____ Date:_____
If lower extremity wounds, have venous or arterial Doppler studies been performed within the last year? ☐Yes ☐No Date:_____ Copy of results: ☐Yes ☐ No

Physician Information:
Referring Physician:
Name:_____Ph:_____Fax:_____
Primary Care Physician:
Name:_____Ph:_____Fax:_____

Insurance Information:
Primary Insurance:_____Secondary:_____
Prior authorization required: ☐Yes ☐No
If yes, authorization #:_____
Date authorization ends_____ And/or # of visits authorized:_____

***Please fax medication list and other info with completed referral form. Thank you.**