Integrity Healing Touch LLC

Date of Referral: _____

Referring Provider: _____

Clinic / Facility Name: _____

Phone: _____ **Fax:** _____

Provider NPI (if available): _____

Patient Information

Patient Name: _____

Date of Birth: _____ **Sex:** ☐ M ☐ F

Address: _____

City/State/ZIP: _____

Phone: _____ **Email:** _____

Insurance Information

Primary Insurance Company _____

Primary Insurance Company Phone Number:_____

Patient ID Number & Group Number (if applicable):_____

Secondary Insurance Company:_____

Secondary Insurance Phone Number:_____

Patient ID Number & Group Number (if applicable)_____

***Attach Copy of Insurance Card if Possible**

Diagnosis / Wound Information (Please provide as much as possible)

Primary Diagnosis / ICD-10: _____

Wound Type: ☐ Diabetic Foot Ulcer ☐ Venous Ulcer ☐ Pressure Ulcer

☐ Post-Surgical ☐ Other: _____

Wound Location(s): _____

Duration of Wound: _____

Is Infection Present? ☐ Yes ☐ No

Has Debridement Been Performed? ☐ Yes ☐ No

Grafting Requested: ☐ Evaluate for Skin Substitute ☐ Follow-up Graft Care

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Clinical Notes (Attach Recent Visit Notes, Labs, or Photos if Available)

_____

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_____

Preferred Contact for Scheduling

☐ Contact Patient Directly ☐ Call Office First

Contact Name: _____ Phone: _____

Referring Provider Authorization

I authorize **Integrity Healing Touch LLC** to evaluate and treat the above-named patient for wound-care under Medicare Part B and applicable payers.

Provider Signature: _____ Date: _____

Fax completed form & supporting documents to:

📠 **(214) 556 - 1216** 📧 referrals@integrityhealingtouch.com 📞 **(214) 444 - 8759**