

# Specialized Wound Referral Data Form

(Internal confidential form for data gathering purposes only)

Name \_\_\_\_\_ Age \_\_\_\_\_

Allergies: \_\_\_\_\_ Vitals: \_\_\_\_\_

Ht: \_\_\_\_\_ Weight: \_\_\_\_\_ Diet: \_\_\_\_\_ Weight + / - \_\_\_\_\_

Medicare A       Hospice      Alert and oriented X \_\_\_\_\_

**Bowel:** continent/incontinent

**Bladder:** Continent/Incontinent/Foley

**\*\*\*\* Please attach a copy of current Physician Orders\*\*\*\***

## Wound/Ulcer Information

Wound Location	Date Found	Current Treatment	Cause

## Laboratory Information

Lab Type	Value	Date Completed
Albumin		
Pre-Albumin		
Total Protein		
WBC		
HGB		
HCT		
BUN		
Creatinine		
HGBA1C		
Other		