

# WOUND CARE REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040



Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
 Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 ICD-10 Diagnosis Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Allergies (please note reaction): \_\_\_\_\_  Latex  
 Current Medications: (list here or attach a medication list): \_\_\_\_\_  
 Comorbidities: (list here or attach a list): \_\_\_\_\_

## INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Regranex (becaplermin)	0.01% Gel	<input type="checkbox"/> Apply to wound(s) once a day for _____ days. <input type="checkbox"/> Apply to wound(s) _____ times per day for _____ days.	<input type="checkbox"/> 15 grams <input type="checkbox"/> _____ grams	
<input type="checkbox"/> Santyl Ointment	250 units/gm	<input type="checkbox"/> Apply to wound(s) once a day for _____ days. <input type="checkbox"/> Apply to wound(s) _____ times per day for _____ days.	<input type="checkbox"/> 30 grams <input type="checkbox"/> 90 grams <input type="checkbox"/> Quantity sufficient per the manufacturer's dosing calculator <input type="checkbox"/> _____ grams	
<input type="checkbox"/> Other Medication				

Treatment History:  New to Therapy  Continuation of Therapy

**Wound Care Plan:**

Wound #1 \_\_\_\_\_ cm x \_\_\_\_\_ cm Location: \_\_\_\_\_  Wound #2 \_\_\_\_\_ cm x \_\_\_\_\_ cm Location: \_\_\_\_\_  
 Wound #3 \_\_\_\_\_ cm x \_\_\_\_\_ cm Location: \_\_\_\_\_  Wound #4 \_\_\_\_\_ cm x \_\_\_\_\_ cm Location: \_\_\_\_\_  
 Wound #5 \_\_\_\_\_ cm x \_\_\_\_\_ cm Location: \_\_\_\_\_  Wound #6 \_\_\_\_\_ cm x \_\_\_\_\_ cm Location: \_\_\_\_\_  
 Total Body Surface Area (TBSA) \_\_\_\_\_ Location(s): \_\_\_\_\_

Prescriber Information

Prescriber Name: \_\_\_\_\_  
 State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Additional Contact Person Name: \_\_\_\_\_  
 Group or Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_  
 Product Substitution Permitted  Dispensed as Written  Date \_\_\_\_\_

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

Ship to Patient  Ship to Prescriber/Clinic  Pick up at Albertsons Companies Pharmacy  
 Date Medication Needed: \_\_\_\_\_

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Ph. 800-834-8778  
 Fax 877-466-8040

E-Scribe Information:  
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