Specialty Service Referral
Wound Care

Sarah Bush Lincoln

SBL Advanced Wound Care
Sarah Bush Lincoln Health Center
1000 Health Center Dr., Suite 302 • Mattoon, IL 61938
217-238-4850 • Fax 217-238-4855

REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral _____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related ❑ Yes ❑ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED
Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
- ❑ Medication and Allergy Lists

Appointment Requested

- ❑ Wound Evaluation and Treatment
- ❑ Hyperbaric Oxygen Therapy

Wound Treatment History

- ❑ Surgical Debridement Date _____
- ❑ Revascularization Date _____
- ❑ Skin Graft Date _____
- ❑ Antibiotics Date _____
- ❑ Amputation Date _____

REFERRING RESPONSE

❑ Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

❑ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____