UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

AT HARFORD MEMORIAL HOSPITAL
501 SOUTH UNION AVENUE, HAVRE DE GRACE, MD 21078-0340
PHONE: (443)843-6600 • FAX: (443)843-6610

PHYSICIAN REFERRAL FORM

Date: _____

Patient Name: _____

Birth date: _____ SS# _____ Sex: ❑ M ❑ F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell/Alternate Phone #: _____

Please send a copy of the following:

❑ current H&P with updated problem list ❑ medication list ❑ any pertinent labs or tests

Indication for Wound Care Consultation and Treatment:

Date of Injury/Wound: _____ Wound Type: _____

Wound Location: _____

Wound Infection Known or Suspected: ❑ Y ❑ N MRSA ❑ Y ❑ N VRE: ❑ Y ❑ N

Symptoms: _____

ICD-9 Codes: _____

Insurance:

Primary:	**Secondary:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone #: _____	Phone #: _____
Policy/ID#: _____	Policy/ID#: _____
Group #: _____	Group #: _____
Policyholder: _____	Policyholder: _____
Relationship: _____	Relationship: _____

Physician Signature: _____ Phone #: _____

Print Name: _____ Fax #: _____

To contact for additional patient information.