INTAKE FORM

Renew Wound Care Center
Ph: (336) 443-5150 Fax: (336) 443-5155
wounds@renew-hw.com
www.renewwoundcarecenter.com

❑ UPDATED INTAKE (only complete patient name & updated information) ❑ 30 DAY REVERIFICATION (Name & DOB only)

FAX _____ REPRESENTATIVE_____ DATE _____

PATIENT INFORMATION				
Patient Name	❑ Male ❑ Female	Phone	Date of Birth	
Scheduling contact if other than patient		Relationship to patient	Phone	
Address	City	State	Zip	Rm # or Gate Code
Is patient currently in an assisted living facility? ❑ Yes ❑ No If YES, name of ALF		Name of ALF Care Coordinator		
POA		Phone		
Billing Address	City	State	Zip	Rm # or Gate Code
Notes: ***Please include: HPI, Past Medical History, and Wound Location. ***				

INSURANCE INFORMATION **Please include copy of insurance card/s**		
Primary Insurance	Member ID	Phone
Secondary Insurance	Member ID	Phone

REFERRAL SOURCE		
Source	Point of Contact	Phone

HOME HEALTH PARTNER			
Name		Phone	Order Fax
If no current HH, is there a preferred HH? ❑ Yes ❑ No Name		Phone	Order Fax
Case Nurse	Phone	DON	Phone

OTHER PARTICIPATING CARE PARTNERS			
Primary Care Physician		Phone	Point of Contact
Requesting Clinical Notes? ❑ Yes ❑ No		Fax	
Skilled Nursing	Phone	Discharge Coordinator	Phone

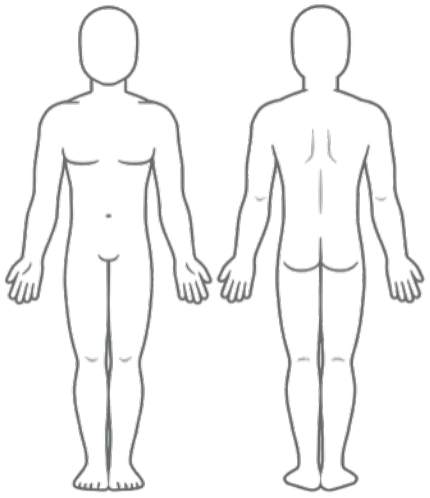
SUSPECTED WOUND ETIOLOGY (IF AVAILABLE)
Check as many as you may suspect apply

❑ Venous insufficiency ❑Post thrombotic ❑Diabetic Ulcer ❑Burn
❑ Non-healing traumatic (e.g. resulting from a fall)
❑ Post surgical (include procedure if known) ❑Pressure injury
Has this wound been treated by healthcare professionals? ❑Yes ❑No
If so, for what period of time? ❑<30 days ❑30-90 days ❑>90 day

OTHER RELEVANT CONDITIONS
Check as many as you may suspect apply

❑ Diabetes ❑ Hypertension ❑ Venous Insufficiency ❑ Malnutrition
❑ Moderate to severe mobility restriction ❑ Edema (including lymphedema)
❑ Arterial Insufficiency ❑ Suspected infection at the wound site

EXAMPLE: Place "X" over area of wound



v8/1-2021