Knoxville Hospital & Clinics
"Committed to You"

Wound Care Clinic
1202 W Howard St.
641-828-7211

Physician Order-Referral
Wound Care Clinic

Fax(641) 842-7030 rrdavis@knoxvillehospital.org

Submit Demographic sheet with patients name, phone number, DOB, and insurance information to fax number listed above.

Patient Name _____ **Date:** _____

Diagnosis (Narrative and-or Valid ICD-9-CM Dx Code): _____

_____

_____

_____

☐ **Due to diabetis mellitus (indicate current disease type and status):**

☐ **Type I** ☐ **Type II** ☐ **Controlled** ☐ **Uncontrolled**

☐ **Due to atherosclerotic peripheral vascular disease**

☐ **Due to other underlying disease process (indicate other underlying disease process):**

_____

_____

Prescription/Order *(check all that apply)*

☐ **Evaluate and Treat**

☐ **Wound Care Management**

☐ **Non-Selective Debridement**

☐ **Selective-Excisional Debridement**

☐ **Ankle-Brachial Index**

☐ **Wound Dressing(s) Change**

☐ **Vacuum Assisted Closure**

☐ **Compression Dressing Application Extremity**

Indicate Extremity:

_____

For patients with more than one wound-burn, it is necessary to indicate which wound-burn treatment is directed.

Frequency: _____ ☐ **To be determind by Wound Care Nurse**

Duration of Prescription-Order: _____
(ninety days unless ordered differently)

Additional Comments: _____

_____

_____

Physician Signature: _____ **Date:** _____