1. *Please fax referral to 520-771-6870*
2. *Email patients@swcatn.com to confirm referral receipt.*
3. *For further inquiries call 520-253-7824*

Incoming Referral

Referring Provider: ______________________________

Fax Number: ___________________________________

Patient Name: _____________________________________ Gender: ______________________

DOB: _____-_____-______SSN: _____-____-______Phone _______-_______-_________

Primary Care Provider: _______________________________ Fax: _______________________

Address: __________________________________ City: ______________ Zip: ____________

Wound Location: ____

Best Approximate Onset of Wound: ____

Wound Diagnosis: ____

Insurance: ____

Home Health Agency: ____________________________________ Fax: __________________

Please include:

- Demographic sheet with insurance information
- Medical history
- Medication list
- Most recent history and physical
- Any pertinent vascular studies (ABI, vein reflux etc.)

Additional Notes: ____

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SWCA-AZ
6565 E.Carondelet Dr.
Suite 301
Tucson, AZ 85710

SWCA AZ
2055 W.Hospital Dr.
Suite 145
Tucson, AZ 85704