WOUND CARE PATIENT BILLING INFORMATION

Our Wound Care Center® (WCC) serves as a hospital outpatient clinic where doctors and nurses treat people with wounds that they may have had for a long time. **Visits to the Center will result in charges from both the hospital and doctor.**

Many times these visits will only result in a charge for a procedure such as a wound debridement, but sometimes they may also include a clinic visit. Sometimes, there may be charges for hyperbaric oxygen therapy, laboratory tests, x-rays, and other services that may be performed in the hospital.

We understand this can be a confusing time and have outlined various ways the payment of the services provided to you can be handled. If you have questions about the process, please feel comfortable discussing this with one of the WCC staff members.

THE HOSPITAL:

When the hospital bills your insurance company(s) for the services you received at the WCC, the bill contains charges for what is called the **technical component**. This fee may also be listed on your bill as the clinic fee or some other hospital specific term. This fee includes the use of the WCC's staff, room, equipment, etc. as well as any supplies that were used. You may also see laboratory charges, radiology (x-ray) charges, and other additional services if they were provided during that billing period. Some hospitals may bill for these additional services on a separate bill.

THE DOCTOR:

Each doctor that sees and treats you will bill separately for their services. Most of the time, this bill will come from his or her office, but sometimes hospitals may bill for the doctor's charges. These charges will be for the **professional component** and includes only the services that the doctor provided.

The WCC doctors are specially trained in providing wound care and the insurance companies know to pay for only one set of services by the codes used on the bill sent to them. They will pay a portion of the service to the hospital and a portion to the doctor. **You will not be billed twice for the same service** even though the description of the services may be the same.

OTHER DOCTORS:

There are different specialists who may be called in on your case, depending on the difficulty of your wounds, and they may submit a bill as well. These may be from the Pathologist for the professional component of the laboratory tests performed, or the Radiologist for the services rendered when x-rays were performed, etc.

These billing practices are consistent within all departments of the hospital as well as within the hospital industry. In addition, these billing procedures are frequently audited by Medicare/Medicaid and accepted as standard practice.

IF YOUR PRIMARY INSURANCE IS MEDICARE:

The hospital will bill Medicare and may send you a courtesy copy of your itemized bill upon request. Medicare will notify you when they have paid their portion of your hospital bill. If you have a secondary insurance, the hospital will also send them a bill for their portion and that company will contact you to let you know when and what they paid to the hospital. After payments are received by either your primary and/or secondary insurance, ***any outstanding balances will be your responsibility.*** This payment is necessary since the services were performed at a hospital outpatient department. If you are responsible for the co-payment balance, your payment per individual HBO treatment, procedure or other service may range from $19 - $88 (co-payments may be as high as $281 if a cellular or tissue based product procedure is performed)

IF YOUR PRIMARY INSURANCE IS MEDICAID:

The hospital will bill Medicaid and may send you a courtesy copy of your itemized bill upon request. Medicaid traditional or Managed Care may require a co-payment that is due at the time of service. The hospital should be able to inform you of your co-payment.

IF YOUR PRIMARY INSURANCE IS AN INDIVIDUAL / GROUP PPO OR HMO:

The hospital will bill your insurance company. You will be responsible for any deductible and/or co-payment amounts. Payment for these items may be expected at the time of service. Insurance verification will help us to identify your appropriate deductible and co-payment amounts. Copays and deductibles can vary significantly among plans and patients should contact their plan if they have questions about these amounts.

IF YOU DO NOT HAVE INSURANCE COVERAGE:

Many hospitals require a payment (either in full or partial) at the time of the visit. If you are unable to pay, many hospitals will work with you to determine if you qualify for some type of assistance or will allow you to set up a payment plan. The center can refer you to the hospital's business office as needed. You cannot be seen in the WCC until these arrangements are completed.

IF YOU HAVE QUESTIONS REGARDING YOUR BILLS / STATEMENTS:

Please call the hospital's business office. Hours of operation are usually between 9:00 am and 4:30 pm (Monday thru Friday). If your question is regarding the provider services, you will need to contact that provider's office.

Patient Signature:_____ Date:_____ Time: _____

Witness Signature:_____ Date:_____ Time: _____

This cost estimate was made based on the date of this publication - 12/1/2015. This cost may vary after 2015.

The ECHN Center for Wound Healing

AGREEMENT TO RECEIVE WOUND CARE
BETWEEN (PATIENT) AND (PROVIDER NAME)

Date: _____

I understand that I am being seen for wound care treatment in order to assist healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Lapses in my treatment, such as missed days or sporadic days, or failure to comply with the plan of care can result in this therapy becoming less effective or ineffective. Thus, I understand that in order for my treatment to be worthwhile, it is important that I receive treatment as scheduled and follow the treatment instructions provided.

I agree to the following conditions: (initial each line signifying agreement)

_____I will appear for treatment as scheduled.

1. If I am unable to appear for a scheduled appointment, I will notify the WCC staff by 8:00 AM on that day. I will, also, make every arrangement possible to reschedule for that same day during regular business hours.

_____I will follow the treatment instructions provided to me and I will actively seek assistance when I find myself unable to comply with the plan of care.

1. I agree to cleanse my wound and apply my dressing as directed by my provider
2. I agree to relieve pressure from my wound if prescribed by my provider.
3. I agree to use swelling control methods if prescribed by my provider.
4. I agree to follow good health practices of diet and exercise as advised by my provider.
5. If I am a smoker, I agree to participate in a program to help me stop smoking, because I realize that this habit may prevent or slow down my wound healing.
6. I agree that I am responsible for notifying the WCC staff immediately if I have any problems, questions or concerns regarding my wound and how I should care for it.

_____I understand that a violation of any of these conditions may result in my discharge from the WCC's program.

_____I agree to be an active participant in my care.

_____ _____
Patient Name/Signature Date Time

_____ _____
Provider Name/Signature Date Time

PATIENT CONSENT TO WOUND CARE TREATMENT

(Note: This form is to be signed by all Wound Care Center Patients. If Patient is going to receive Hyperbaric Oxygen Therapy, then Patient must also execute the Patient Consent to Hyperbaric Oxygen Therapy Consent Form).

PATIENT NAME:_____ DATE OF BIRTH:_____
HOSPITAL: **ECHN Center for Wound Care at Manchester Memorial Hospital**

Patient hereby voluntarily consents to wound care treatment by Provider, Hospital and its contractor HEALOGICS, INC. ("HI") and their respective employees, agents, representatives, and affiliated companies (hereinafter sometimes collectively referred to as Wound Care Center – "WCC"). Patient understands that this Consent Form will be valid and remain in effect from the date of signature, as long as Patient receives care, treatment and services at the Wound Care Center. A new consent will be obtained when a Patient is discharged from the WCC and returns for care, treatment or services. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

1. **General Description of Patient's Medical Condition and Wound Care Treatment:** Patient acknowledges that Provider has explained Patient's general medical condition to Patient. Patient further acknowledges that Provider has informed Patient that Patient's treatment in the WCC may include, but shall not be limited to: debridements, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as blood, urine and other studies), x-rays, hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a provider. Patient acknowledges that Provider has given Patient the opportunity to ask questions, Patient has asked questions, and Provider has answered all of Patient's questions regarding the treatments that may be provided to Patient in the WCC.

2. **Benefits of Wound Care Treatment:** Patient acknowledges that Provider has explained that the potential benefits of treatment in the WCC may include: enhanced wound healing and reduced risks of amputation and infection.

3. **Risks/Side Effects of Wound Care Treatment:** Patient acknowledges that Physician has explained that treatment in the WCC may cause side effects and involve risks including, but not limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissues, possible damage to organs, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin preparation solutions, removal of healthy tissue, and prolonged healing or failure to heal.

4. **Likelihood of achieving goals:** Patient acknowledges that Provider has explained that, by following Provider's plan of care, Patient is more likely to have a favorable outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Therefore, Patient specifically acknowledges and agrees that no representation made to Patient by Provider, Hospital or HI constitutes a **Warranty** or **Guarantee** that Patient will experience any result or cure.

5. **Refusal of WCC Treatment:** Patient acknowledges that Patient has been made aware that Patient may refuse treatment in the WCC. Patient acknowledges that, if Patient refuses treatment in the WCC, Patient may not have the opportunity to experience certain advanced wound care therapies that might benefit the patient. . In lieu of treatment in the WCC, Patients may continue a course of treatment with his or her personal provider or forego any treatment.

6. **Alternative to WCC Treatment:** Patient acknowledges that Patient has been made aware that, in lieu of treatment in the WCC, Patients may continue a course of treatment with Patient's personal provider or forego any treatment. Patient acknowledges that Provider has explained that, if Patient chooses to continue a course of treatment with Patient's personal provider or forego any treatment, Patient may not experience the risks/side effects associated with treatment in the WCC (see Risks/Side Effects of Wound Care Treatment above). However, Patient may experience prolonged healing or failure to heal, infection and possible amputation if Patient's wound is on one of Patient's limbs.

7. **General Description of Wound Debridements:** Patient acknowledges that Provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment in the WCC, multiple wound debridements may be necessary and will be performed by an authorized practitioner.

Patient Initials: _____

PATIENT CONSENT TO WOUND CARE TREATMENT

8. **Risks/Side Effects of Wound Debridement:** Patient acknowledges that Provider has explained that the risks or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin preparation solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that Provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that Provider has explained that drainage of an abscess or debridement of necrotic (dead) tissue may result in dissemination of bacteria and bacterial toxins into the bloodstream and thereby cause severe sepsis. Patient specifically acknowledges that Provider has explained that debridement will make Patient's wound larger due to the removal of necrotic tissue from the margins of the wound.

9. **Patient Identification and Wound Images:** Patient understands and consents to having images (digital, film, etc.), taken of Patient and all Patient's wounds with their surrounding anatomic features. The purpose of these images is to monitor the progress of wound treatment and provide for continuity of care. Patient further agrees that Patient's referring provider or other treating providers may receive medical information, including these images, regarding Patient's treatment plan and results. The images may be considered protected health information (PHI) and will be handled, maintained, and retained in a confidential, secure, and protected manner in accordance with applicable laws, regulations, and Hospital privacy and retention policies. Patient understands that the Hospital will retain ownership rights to these images and Patient expressly waives any and all rights to royalties or other compensation for these images. Patient understands that Patient may view or obtain copies of the images in accordance with applicable laws, regulations, and policies. Images that identify the Patient will only be released and/or used outside the WCC upon written authorization from the Patient or Patient's legal representative.

10. **Use and Disclosure of Protected Health Information (PHI):** Patient authorizes and consents to HI's use of Patient's PHI, stored in the HI wound database for purposes of, education, research, payment and billing by the Hospital, quality assessment and improvement activities, and development of proprietary clinical processes and healing algorithms. PHI includes both medical and demographic information including, but not limited to, the results of Patient's medical history, physical examination, wound images, cell phone numbers and other contact information, and other information stored in HI's database. Patient's PHI may be disclosed by HI, in accordance with HI's agreement(s) with Hospital, to third parties providing services to HI and/or Hospital who have executed a business associate agreement or subcontractor agreement, with Hospital or HI. Any such disclosure of PHI that is not for treatment, payment, or operational purposes, shall be done in de-identified forms, unless otherwise permitted by law. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Hospital's Notice of Privacy Practices ("Notice"), and any applicable related law, rules, and regulations. Patient specifically authorizes use and disclosure of patient's PHI by HI, its affiliates, and business associates for purposes related to treatment, payment, and health care operations and as described in the Notice. For example, HI may disclose PHI to business associates or subcontractors for purposes such as auditing, quality assurance, payment, or other permissible purposes. **Patient understands that, if applicable, PHI may include information relating to genetic conditions, HIV, mental health, substance abuse, and other sensitive conditions, and patient specifically authorizes that information to be used and disclosed as described in this form.** If Patient wishes to request a restriction to how his/her PHI may be used or disclosed, Patient may send a written request for restriction to HI's Chief Compliance Officer at 5220 Belfort Road, Suite 130, Jacksonville, Florida, 32256. If the PHI is owned and/or maintained by the Hospital or another entity, HI will direct Patient's restriction request to the appropriate party.

11. **Financial Responsibility:** Patient understands that, Patient is responsible for any costs associated with Patient's treatment that are not covered by insurance. Patient authorizes Patient's PHI, as described above to be released to any payer, billing agents, and other third parties for payment purposes. For example, medical information may be disclosed to determine any insurance benefits or the benefits payable for services provided to Patient as part of Patient's treatment at the WCC.

Patient Initials: _____

PATIENT CONSENT TO WOUND CARE TREATMENT

Patient hereby acknowledges that Patient has read this document or had it read to him or her, understands and agrees to the information set forth in this document, and has had the opportunity to ask questions and receive answers to questions about this document and the information set forth in this document.
By signing below, Patient: (1) consents to the care, treatment, and services explained to Patient by Provider and described in this document ; (2) consents to the creation of images to record Patient's wounds; and (3) consents to the use and disclosure of Patient's PHI as set forth in this document or as otherwise permitted by applicable laws, regulations, and policies.

Patient Signature or parent (if minor)	Relationship	Date	Time

Witness Signature	Date	Time

Interpreted by: _____(if applicable)

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

Legal Guardian or Legal Representative	Date	Time

Printed Name: _____Relationship: _____

The undersigned Provider has explained to Patient (or Patient's legal representative), the nature of Patient's proposed treatment or procedure(s), reasonable alternatives to such treatment or procedure(s), likelihood of achieving Patient's goals with regard to such treatment or procedure(s), and the potential benefits, risk, side effects, complications and consequences relating to such proposed treatment or procedure(s).

Signature of Provider	Date	Time

Patient Initials: _____

ECHN
Eastern Connecticut Health Network, Inc.

MANCHESTER MEMORIAL HOSPITAL
71 Haynes Street, Manchester, CT 06040

ROCKVILLE GENERAL HOSPITAL
31 Union Street, Vernon, CT 06066

INFORMED CONSENT FOR SURGERY AND/OR SPECIAL PROCEDURE/TREATMENT

Name of Patient:

I hereby authorize The ECHN Center for Wound Healing physician and/or such assistants, that may include resident physicians in training or medical students, as may be selected by him/her to perform the following operation/procedure/treatment: sharps debridement and advanced wound care procedures

The nature and purpose of the operation/procedure identified above has been explained to me, and I have been informed of possible risks, benefits, complications, and alternative procedures and treatments, including not having the operation/procedure.

Possible Risks and Complications (including, but not limited to):

bleeding

pain

increased drainage

☐ **Blood transfusion or the use of blood components is NOT APPLICABLE at this time.**

If blood transfusion or use of blood components is applicable:

☐ **I CONSENT** to receive blood/blood products if it is deemed necessary by my physician.

☐ **I DO NOT CONSENT** to receive blood/blood products. I hereby release ECHN, this hospital, their employees, agents, directors and officers, and the attending physician from any and all liability/responsibility whatsoever arising from any risks or possible adverse consequences, including death, which may result due to my refusal to permit the use of blood or blood products.

Patient Consent

I have read and fully understand this 2-page form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Signature of patient or person authorized to consent for the patient | *Date* | *Time*

Legal relationship of authorized person

Practitioner/Allied Health Professional Declaration

I have explained the benefits, risks and alternatives of the proposed surgery and/or special procedure/treatment, including the possibility of blood transfusions and the use of blood components, as applicable. I have addressed with the patient the likelihood of achieving his/her goals. I have fully answered all questions posed to me.

Practicioner/AHP Signature | *Date* | *Time*

Print Name/Mnemonic

ECHN
Eastern Connecticut Health Network, Inc.

MANCHESTER MEMORIAL HOSPITAL
71 Haynes Street, Manchester, CT 06040

ROCKVILLE GENERAL HOSPITAL
31 Union Street, Vernon, CT 06066

Informed Consent for Surgery and/or Special Procedure/Treatment

Unforeseen Conditions

I understand that during the course of the operation(s) or procedure(s) unforeseen conditions may arise that may necessitate procedures different from, or in addition to, those planned. I consent to any additional operations or procedures that my physician considers necessary under the circumstances. I also understand that no guarantees have been made to me as to the results that may be obtained.

Anesthesia

I consent to the administration of such sedating medications and anesthetics as may be necessary for the performance of this operation or procedure, understanding that all forms of anesthesia involve risks which uncommonly may include injury, or even death.

Tissue Disposal, Support Personnel and Observers, Photographs and Video

I agree to the disposal of any tissue specimens, organs, implants, or foreign bodies removed. I accept the presence of technical support personnel including medical product representatives who provide technical expertise to my surgeon(s) or who may program implantable devices (e.g., pacemakers), and also medical/nursing/allied health observers. Photographs or videos may be taken during the surgery or procedure for documentation and/or educational purposes.

Surgical Tasks (when applicable)

I understand that some significant surgical tasks may be perfomed by qualified assistant(s) other than the primary surgeon identified in this consent.

Physicians/Assistants as Independent Contractors

I understand that many of the physicians and assistants who will provide medical care to me are not employees or agents of the hospital, but rather, are independent contractors who have been granted the privilege of using the hospital's facilities for the care and treatment of patients.

Transfusion of Blood or Use of Blood Components

I have been informed that I need, or may need, a transfusion of blood and/or one of its components (e.g., fresh-frozen plasma, platelets) in the interest of my health and proper medical care.

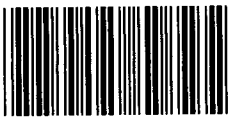
The associated risks, benefits and alternatives to receiving transfusion(s) have been described to me. Although blood transfused at this hospital is collected from screened donors and is tested for various markers of infectious disease, absolute assurance cannot be given that an infectious disease will not be transmitted to me. I realize that the following risks and hazards may occur in connection with blood/blood product transfusion.

Occasional Complications: Fever, chills, allergic reactions (such as hives).

Infrequent Complications: Transmission of hepatitis with or without clinical symptoms, heart failure due to excessive transfused fluid.

Very Rare Complications: Hemolysis (destruction of transfused red blood cells), transmission of other infectious disease (including AIDS), shock, chest pain and death.

This transfusion consent is valid for the duration of the stay related to this procedure.



Patient Label

PATIENT HISTORY

GENERAL INFORMATION		DATE:	
▲ Name		▲ Primary Phone	
▲ Address		Secondary Phone	
▲ City		State	Zip
▲ E-mail	▲ Date of Birth	▲ Age	▲ Sex

SOCIAL HISTORY

Do you live alone: □ No □ Yes	Do you drive: □ No □ Yes	Employed: □ No □ Yes
What is the highest school grade you completed? □ 1-6 □ 7-9 □ 10 □ 11 □ 12 □ Some college □ College graduate		
Marital Status: □ Separated □ Divorced □ Married □ Single □ Widowed		Spouse Name:
Do you smoke: □ No □ Yes If Yes, for how many years:	How many packs per day:	If quit, when:
Do you drink alcohol: □ No History □ Prior History □ Current History		Type:
Do you use recreational drugs: □ No □ Yes If Yes, amount:		Type:
Caffeine Use: □ No □ Yes If Yes, for how many years:	How many cups per day:	
Financial Concerns: □ Yes □ No	Food/Clothing/Shelter Needs: □ Yes □ No	
Support System Intact: □ Yes □ No	Transportation Concerns: □ Yes □ No	
How will you travel to center: ☐ Car ☐ Ambulance ☐ Ambulette ☐ Public ☐ Other		

EMERGENCY CONTACT INFORMATION

Name	Primary Phone
Relationship	Secondary Phone

▲ What provider referred you to the Wound Care Center®?

Name	Specialty	Phone	
Address	City	State	Zip

▲ Who is your primary provider?

Name	Specialty	Phone	
Address	City	State	Zip

▲ If your provider did not refer you, how did you hear about our Wound Care Center®?

☐ Self-referral ☐ Extended Care Facility (SNF, LTAC, Nursing Home) ☐ Advertising

☐ Former patient ☐ Home Health ☐ Friend/Family
☐ Recently discharged from this hospital ☐ Recently discharged from another hospital

Please provide contact information (if applicable):

Home Health Agency:	Phone
Nursing Home/Skilled Nursing Facility:	Phone
Pharmacy:	Phone

Do you have any of the following?

Advance Directive: □ Yes* □ No	Living Will: □ Yes* □ No	Medical Power of Attorney: □ Yes* □ No	Do Not Resuscitate: □ Yes* □ No

*Copy required for chart. Requested by: _____ Date: _____ Time: _____
□ Copy provided. Signature: _____ Date: _____ Time: _____

Name of Person Completing Form: _____ **Relationship to Patient:** _____
Signature: _____ **Date:** _____ **Time:** _____

Reviewed By: _____ **Date:** _____ **Time:** _____

Patient Label

PATIENT HISTORY

WOUND HISTORY

Wound location:		
When did you first notice the wound?	Has it ever healed and then re-opened? □ Yes □ No	
How did your wound start? □Bite □ Blister □ Bruise □ Bump □ Chemical Burn □ Footwear □ Frostbite □ Gradually Appeared □ Not Known □ Other Lesion □ Pimple □ Pressure □ Radiation Burn □ Surgical □ Thermal Burn □ Trauma		
How have you been treating your wound until now?		
Have you had any lab work done in the past month? ☐ No ☐ Yes	If Yes, Who Ordered?	
Have you ever had bacteria that resisted antibiotics)? ☐ No ☐ Yes		If Yes, Date:
Have you ever had a bone infection? ☐ No ☐ Yes		If Yes, Date:
Have you had any tests for blood flow in your legs? ☐ No ☐ Yes		If Yes, Date:
If Yes, Where was it done:	Who ordered?	
Have you had any other problems with your wound? ☐ Infection ☐ Swelling ☐ Other		

PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

	Yes	No		Yes	No
Cataracts (Cloudy vision)			Cirrhosis (Liver problems)		
Glaucoma (Eye disease)			Colitis/Crohn's (Bowel problems)		
Chronic Sinus problems/congestion			Hepatitis (Type:)		
Middle ear problems			Thyroid Disease		
Ear Surgery			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis (Type:_____)		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Sickle Cell Disease			Raynaud's Syndrome (Problem with blood flow to your fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (Stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)					
Deep Vein Thrombosis (Blood clot in leg)			Surgery		
Hypertension (High blood pressure)			Anorexia/bulimia		
Hypotension (Low blood pressure)			Confinement Anxiety (Fear about being in a closed space)		
Myocardial Infarction (Heart attack)					
Peripheral Arterial Disease (Problem with blood flow in your legs)			Peripheral Venous Disease (Problem with blood vessels in your legs)		
Vasculitis (Inflammation of your blood vessels)			Phlebitis (Inflammation of the veins in your legs)		

Name of Person Completing Form:_____ **Relationship to Patient:**_____
Signature: _____ **Date:** _____ **Time:** _____

Reviewed By: _____ **Date:**_____ **Time:** _____
Reviewed By: _____ **Date:**_____ **Time:**_____

Patient Label

PATIENT HISTORY

FAMILY MEDICAL HISTORY (*Please indicate with a checkmark if any of your family members have/had this condition)*

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

HOSPITALIZATION/SURGERY HISTORY (*Please list all)*

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center® for your first visit.

For Healthcare Provider Use Only

NOTES:

Name of Person Completing Form:_____ **Relationship to Patient:**_____
Signature: _____ **Date:** _____ **Time:** _____

Reviewed By: _____ **Date:**_____ **Time:** _____
Reviewed By: _____ **Date:**_____ **Time:**_____

Patient Label

INTERDISCIPLINARY CASE MANAGEMENT GUIDE

Physician Name: _____ **Case Manager Name:** _____

Wound(s) Primary Etiology: **Wound(s) Secondary Etiology:**

	Date: Week 0 (Initial Visit)	Date: Week 1	Date: Week 2	Date: Week 3	Date: Week 4	4 week Review OK	4 week Review NA	Comments
I. OPTIMIZATION OF HOST FACTORS								
Patient History								
Wound Assessment/Measurement								
Photo								
Labs: CBC, CMP, pre-Albumin, HgbA1C Other:								
Risk & Education Assessment:								
Consults: ☐ Diabetic Education ☐ HBO ☐ Home Health _____ ☐ Infectious Disease ☐ Nutrition ☐ Physical Therapy ☐ Primary Care Physician ☐ Social Services ☐ Vascular ☐ Other								
II. ADEQUATE PERFUSION								
TcPO2/Laser Doppler/Skin Perfusion Pressure/Handheld Doppler/ABI								
Arterial/Venous Studies								
Arteriography								
Vascular Consult								
Endovascular/ Surgical Procedure								
III. RESOLUTION OF INFECTION AND INFLAMMATION & OPTIMAL WOUND MICROENVIRONMENT								
Biopsy								
Culture								
X-Ray / Scan/ Nuclear Medicine								
Systemic Treatment (Oral/I.V./I.M.)								
Topical Treatment (Wound)								
IV. REMOVAL OF VIABLE/NON-VIABLE TISSUE								
Procedure Location: Inpt/Ambulatory/Clinic								
V. ENHANCE TISSUE GROWTH								
Growth Factor								
Autologous Platelet Application								
Bioengineered Tissue/Dermal Substitutes								
Negative Pressure Wound Therapy								
Hyperbaric Oxygen Therapy								
Graft/Flap/Amputation/Surgical Closure								
Dressing Type								
VI. RESOLUTION OF EDEMA & OFFLOADING, PRESSURE REDISTRIBUTION, INJURY PREVENTION								
Stockings/Compression Wrap, Pump								
Other:								
Total Contact Cast / Walking Boot								
Support Surface (Mattress/Cushion)								
MISCELLANEOUS								
Other								
Other								
Other								
Initials/Date/Time								

Case Manager Signature:_____ Initials:_____ Date: _____ Time: _____
Case Manager Signature:_____ Initials:_____ Date: _____ Time:_____
Case Manager Signature:_____ Initials:_____ Date: _____ Time: _____
Case Manager Signature:_____ Initials:_____ Date: _____ Time:_____

THIS FORM IS NOT A PART OF THE PERMANENT MEDICAL RECORD.