MountainCare
CARING FOR OUR WNC NEIGHBORS

Seating and Wheeled Mobility Clinic Phone 828-820-2828
Return by email <BarbaraC@mtncare.org> or FAX 828-277-4855

REFERRAL FORM

Physicians – please send clinical notes with this referral form or your demographic form

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Referred By (name, credentials and phone #): _____

Client's Full Name: _____ Preferred Name: _____

Birth date: _____ Male _____Female_____ Marital Status: _____

Address: _____County: _____

Home Phone: _____ Mobile phone: _____

Client and/or Caregiver E-mail Address: _____

Living with whom: _____ Relationship_____

Please list one other person's contact name and number(s):

Name: _____Relationship: _____

Home phone: _____Business phone: _____ Cell/Beeper#_____

Insurance Companies and ID #'s:

_____

_____

Primary Care Physician and phone number: _____

Diagnosis: _____Height_____Weight_____

Reason for referral: _____

Do you have a current pressure injury? Yes No

What is the location, size and stage of this wound? _____

Do you have a preferred Supplier for your wheelchair needs? Yes No

If so, who is the supplier that you work with: _____

Available days for appointment: Mon. Tues. Wed. Thurs. Fri. (Circle days that apply)

Preferred approximate time of day for appointment: 9:30 am 12:30 pm 2:30 pm