



United Wound Care Centers of Rockwall
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UnitedWoundCareCentersRockwall.com

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WOUND CARE REFERRAL FORM

Date: _____ In Home _____ In Clinic _____

PATIENT INFORMATION:

Patient Legal Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

Primary Insurance: _____

Policy/ID Number: _____ Insurance Phone Number: _____

Secondary Insurance: _____

Policy Number: _____

REASON FOR REFERRAL/DIAGNOSIS:

Referring Physician Office/Provider Name: _____

Referring Physician Signature: _____

Phone Number: _____ Fax Number: _____

Please **fax** completed referral form to **888-927-0535**

Thank you for referring your patient

Dr. Eric Ray NPI#1598965428 * Kanita Smith NPI# 1689216566 * Kimberly King NPI# 1043029846