

WOUND CARE REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040



Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Regranex (becaplermin)	0.01% Gel	<input type="checkbox"/> Apply to wound(s) once a day for _____ days. <input type="checkbox"/> Apply to wound(s) _____ times per day for _____ days.	<input type="checkbox"/> 15 grams <input type="checkbox"/> _____ grams	
<input type="checkbox"/> Santyl Ointment	250 units/gm	<input type="checkbox"/> Apply to wound(s) once a day for _____ days. <input type="checkbox"/> Apply to wound(s) _____ times per day for _____ days.	<input type="checkbox"/> 30 grams <input type="checkbox"/> 90 grams <input type="checkbox"/> _____ grams	
<input type="checkbox"/> Other Medication				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Wound Care Plan:

☐ Wound #1 _____ cm x _____ cm Location: _____ ☐ Wound #2 _____ cm x _____ cm Location: _____
☐ Wound #3 _____ cm x _____ cm Location: _____ ☐ Wound #4 _____ cm x _____ cm Location: _____
☐ Wound #5 _____ cm x _____ cm Location: _____ ☐ Wound #6 _____ cm x _____ cm Location: _____

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Prescriber Signature: _____

Product Substitution Permitted

Date

Dispensed as Written

Date

Delivery Information

Ship to: ☐ Patient ☐ Prescriber/Clinic
☐ Pick up at an Albertsons Companies Pharmacy

Address: _____

Phone: _____

Date Medication Needed: _____

It's as simple as **caring.**

Ph. 800-834-8778
Fax 877-466-8040

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100