



South Bay Wound Care

Marc Hare, MD CWS

Patient Referral Form

Urgent STAT Routine

Chula Vista Location

1111 Broadway Suite 305
Chula Vista, CA 91911
P: (619) 567-0499
F: (619) 567-2323

Patient Information

Last Name: _____ First Name: _____

Home: (____) _____ Cell: (____) _____

DOB: ____/____/____

Patient's Insurance Information

Primary Insurance: _____ Authorization# _____

Secondary Insurance: _____

Reason for consultation:

ICD-10: _____

Referring Physician Information

Physician/Practice Name: _____ Date: _____

Phone: (____) _____ Fax: (____) _____

Please fax referral form including: demographics, Insurance information, MD notes,
medication list, most recent labs and imaging studies if applicable

Fax to: (619) 567-2323