MEDICAL RESPITE CARE PROGRAM
RESPITE WOUND REFERRAL FORM

RESPITE REFERRAL LINE: 720-422-5938

(This form must be included with Respite Referral for wound care patients)

Date: _____
Name of Patient: _____

Does patient have any infectious diseases (including but not limited to HIV, Hepatitis, MRSA, VRE, TB), etc? ☐ Yes ☐ No
If yes – Stop; please call Respite Phone 720-422-5938 to confirm a habitable room is available.

Wound Description: _____
_____
_____
_____

Dimensions: Height _____ Width _____ Depth _____

Specific Wound Care Orders: Must be completed by referring provider. (see attached: will not be accepted)
1. Cleanse with _____ (normal saline, wound cleanser, etc.) on a _____ Basis (frequency – daily, QOD**,** etc).

2. Apply _____ (Silvadene, Antibiotic Ointment, any topical medications, etc.) on a _____ basis. (Frequency – daily, QOD**,** etc.).

3. Cover wound with _____ (tegaderm, clean 4x4, kerlix, etc.).
4. Secure dressing with _____. (Tape, Kerlix, Cast tubing, etc.).
5. Additional Orders: _____
_____
_____
_____
_____

Has patient been educated on how to perform self dressing changes? ☐ Yes ☐ No
If No Please ensure patient education is performed before respite referral.

Has patient demonstrated that he/she can perform specified wound care his/herself if necessary?
☑ Yes ☐ No

Has patient been educated regarding proper wound supply biohazard disposal and given a biohazard bag for disposal of contaminated dressings? ☐ Yes ☐ No (must be yes to refer to Respite)

Patient must be given at least 3 days worth of dressing supplies and biohazard bag to be referred to Respite.

Does patient have 3 days worth of dressing supplies and biohazard bag. ☐ Yes ☐ No