Telewound Care Network
PATIENT ENROLLMENT FORM

PATIENT NAME: _____ _____ _____ _____ _____
First Middle Last ID# Date

ADDRESS: _____

PHONE NUMBER: ( ) _____ - _____ COUNTY OF RESIDENCE: _____

RACE: _____ SEX:_____ DOB:_____ SS#:_____

PRIMARY CARE PHYSICIAN NAME: _____ PHONE#: ( ) _____ FAX#: ( )_____

DIABETES MANAGER NAME: _____ PHONE#: ( ) _____ FAX#: ( )_____

EMERGENCY CONTACTS:

NAME: _____ RELATIONSHIP:_____

PHONE NUMBER ( ) _____ - _____

RELEVANT MEDICAL HISTORY
(Check All That Apply)

Anemia	Yes __ No __ Currently __	High Cholesterol	Yes_ No_ Currently __
Asthma	Yes __ No __ Currently __	High Blood Pressure	Yes_ No_ Currently __
COPD	Yes __ No __ Currently __	Leg Pain with Exertion	Yes_ No_ Currently __
Jaundice/ Hepatitis	Yes __ No __ Currently __	Cardiac Bypass	Yes_ No_Last 6 mos__
Kidney Disease	Yes __ No __ Currently __	Stroke/ CVA	Yes_ No_Last 6 mos__
End Stage Renal Disease	Yes __ No __ Currently __	Coronary Artery Disease (CAD)	Yes_ No_Currently__
Dialysis	Yes __ No __ Currently __	CHF	Yes_ No_Currently __
Organ Transplant	Yes __ No __ Last 6 mos. __	Lupus	Yes_ No_Currently __
Cancer	Yes __ No __ Currently __	Rheumatoid Arthritis	Yes_ No_Currently __
Deep Vein Thrombosis	Yes_No __ Last 6 mos __		

ALLERGIES – DRUG Yes_No __ ALLERGIES - FOOD Yes_ No_
ALLERGIES – OTHER Yes_No_ (List all allergies) _____
DIABETES Yes_No_TYPE 1____ TYPE 2 _____ GESTATIONAL DIABETES Yes_No_

PAST SURGERIES AT/OR AFFECTING WOUND AREA (List all in the last five years)

THERAPY

Radiation	Yes_No_Currently __	Chemotherapy	Yes_No_Currently __
Radiation in wound area	Yes_No_Currently __	Methotrexate	Yes_No_Currently __
Prednisone/ other steriods	Yes_No_Currently __	Sirolimus	Yes_No_Currently __
Cytoxan	Yes_No_Currently __	Other	Yes_No_Currently __

BP_____ HT_____(inches) WT_____(lbs) WAIST (Umbilicus) _____(inches
PATIENT NAME (PG 2 ENROLL) _____

COMMUNICATION BARRIERS

HEARING LOSS	Yes_No __	SPEECH (APHASIA)	Yes_No __
VISUAL PROBLEM	Yes_No __	ABILITY TO COMPREHEND	Yes_No __
LANGUAGE (non-English)	Yes_No __	OTHER (List)_____	Yes_No __
NEED INTERPRETER	Yes_No __		

PRIMARY WOUND DIAGNOSIS: _____

COMPLICATING DIAGNOSIS(ES): _____

CONDITIONS CURRENTLY REQUIRING TREATMENT

---

1. How long has this wound been present? (circle one)
a) 1 month or less
b) Between 1 and 3 months
c) Between 4 and 6 months
d) Longer than 6 months

Onset of wound (approx. date)_____

2. Treatment for this wound started by (circle one):
a) Patient/ patient caregivers
b) Physician in their clinic
c) Hospital staff
d) Wound Clinic staff
e) Other _____

3. Cause of wound (circle one)
a) Injury from bump or fall
b) Scrape or skin tear
c) Surgery
d) Object in shoe or on floor
e) Burn
f) Infection
g) Pressure ulcer from laying or sitting
h) Other _____

Is pulses present in feet? Yes_No _

Is Edema present? Yes_No _

SITE WHERE PATIENT RECEIVES WOUND CARE

PATIENT'S HOME	Yes_No __	WOUND CLINIC	Yes_No __
HOME HEALTH	Yes_No __	PHYSICIAN OFFICE	Yes_No __
LTC	Yes_No_	HEALTHCARE CLINIC	Yes_No __

MOBILITY

Ambulatory without cane or walker	Yes_No __	Bedbound but self moves	Yes_No __
Ambulatory with cane or walker	Yes_No __	Bedbound total care	Yes_No __
Transfer assist to chair or W/C…	Yes_No __	.# of hour/day in chair_____	
Full transfer to chair or W/C	Yes_No __	.# of hour/day in chair _____	

PRIMARY NURSE _____ **PHONE** _____

CAREGIVER NAME(S) _____ **PHONE** _____

AGENCY /FACILITY **PHONE**

AGENCY ADDRESS **CITY**

AGENCY CONTACT PERSON

REFERRING AGENCY /FACILITY **PHONE**

PATIENT NAME (PG 3 TELEHEALTH GROUP ONLY)

TELEMEDICINE READINGS

	Baseline Readings/Test Results	**Alert On**		**Trend Reports to MD:**
		_Yes	**_No**	
Use Default Parameters Or Complete		***Low***	***High***	PRN_____
				Weekly_____Monthly_____
Temperature				
Weight				Comments:
Systolic BP				
Diastolic BP				
Blood Glucose –Fasting				
Blood Glucose – Pre-meal				
Blood Glucose - 2 hr after meal				
Blood Glucose - Bedtime				

TELEMEDICINE EQUIPMENT

BP Cuff #_____ Standard _____ Pediatric _____ X-tra large _____

Scale #_____

Glucose Meter #_____

Videophone # _____