***Comprehensive Wound Management to Your Door…***

***Telehealth and/or On-Site PPE Protected Medically Necessary Visits***

**Wound & Medical Outreach Clinic LLC**

**NPI# 1881229532**

[**www.wmoclinic.com**](http://www.wmoclinic.com) **contact @wmoclinic.org**

**Fax (800) 351-2611 Voice & Appt (813)777-1591**

**USPS Mail-13194 Hwy 301 South #229, Riverview FL 33578**

**Providing Medical Management for the Complex Adult over 30 years**

**Initial Facility Information**

***Please Fax to (800) 351-2611 or Email contact@wmoclinic.com***

**Facility Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility Physical Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Director of Nursing Name & Contact Info:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designated Staff Contact(s) for Communication and Receipt of Medical Records: contact DON**

**Direct Staff/Care Station(s) Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Multiple Care Stations**

**Cell # (if allowed per facility) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Fax for Medical Records #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secure Email Primary Contact if available \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Residents use different/individual Pharmacies**

**Preferred DME Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Variable**

**Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Home Health Agencies if Resident Requires Skilled Nursing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **HH Agency Name** | **Phone#** | **Fax #** | **Specific Nurse Requested?** |
| **#1** |  |  |  |  |
| **#2** |  |  |  |  |
| **#3** |  |  |  |  |

**Contact & Fax# to send our Provider Credentialing Packet for your Administrative review:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Name & Fax # or email to discuss use of Skin Observation & Reporting Tool:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Interested in additional educational tools and Inservice? Yes No If so what would be helpful? Ex: First Aid for Skin Tears**