WOUND AND HYPERBARIC REFERRAL FORM

PATIENT DEMOGRAPHICS *(may attach face sheet instead)*

Today's Date:		Patient DOB:	
Patient Name:		❑M ❑F	
Primary Care Physician:		Phone:	
Address:	City:	State:	Zip:
Phone:	Alternate Phone:		

PATIENT INSURANCE INFORMATION *(may attach face sheet instead)*

Primary:	ID#:	Group#:
Phone:		
Secondary:	ID#:	Group#:
Phone:		

Is patient in a nursing home?	❑ No ❑ Yes	Facility name:		
Is patient receiving home health care?	❑ No ❑ Yes	Agency name:		
Auto or workers' compensation claim?	❑ No ❑ Yes	Date of injury:		
Is patient in the hospital?	❑ No ❑ Yes	Room No.	Is this a swing bed?	❑ No ❑ Yes

REFERRAL REASON	***Wound Location***		***Wound Location***
❑ Arterial/ischemic ulcer		❑ Compromised skin graft or flap	
❑ Diabetic foot ulcer		❑ Crush injury	
❑ Pressure injuries/ulcer		❑ Non-healing, post-surgical wound	
❑ Venous ulcer		❑ Traumatic wound	
❑ Late effects of radiation		❑ Other	
❑ Hyperbaric oxygen therapy		Indication:	

ADDITIONAL COMMENTS:

Is patient on antibiotics?	❑ No ❑ Yes	RX name:
Is patient on blood thinners?	❑ No ❑ Yes	RX name:

REFERRER INFORMATION

Referral Source:	❑ Physician	❑ Discharge Planner	❑ Nursing Home	❑ Nurse Practitioner
	❑ Home Health	❑ PA	❑ Other:	

Referrer Name:	Phone:	Fax:
Referral Office Contact:	Phone:	Ext:

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.

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