NEW PATIENT REFERRAL FORM

Referral Center Use Only:
Appt. Date: _____ FIN # _____
Appt. Time: _____ Conformation Call Made: ☐
Medical Record # _____ Transportation Scheduled: ☐

THIS IS A REFERRAL FOR: Wound Care Center ☐ Hyperbaric Oxygen Therapy Center ☐

Many insurance plans require prior authorization and/or physician referral which may take up to 14 days. If the patient needs to be seen earlier, please indicate: ☐ URGENT ☐ Routine

Today's date:		Social Security No.:
Patient's Name:		Date of Birth:
Current Address:		Zip Code:
Mailing Address (if different from above):		Zip Code:
Primary Phone #:	Secondary Phone #:	Other:
Is English the patient's primary language? ☐ YES ☐ NO , if no, please indicate primary language:		
Referring Physician:	Phone #:	Fax #:

PCP:	Can patient ambulate independently? ☐ YES ☐ NO
DX:	Transport Requires: ☐ Stretcher ☐ Wheelchair
Does patient have an open wound? ☐ YES ☐ NO	How many wounds?
Wound Location: ☐ Right Foot ☐ Left Foot ☐ Right Leg ☐ Left Leg	Is patient diabetic? ☐ YES ☐ NO
☐ Trunk ☐ Other (specify):	If yes: ☐ Type 1 ☐ Type 2 ☐ Controlled ☐ Uncontrolled

Health Insurance Information

Primary Insurance:	Subscriber:	Sub ID:
Secondary Insurance:	Subscriber:	Sub ID:

Needed Documentation

Please fax patient history, physical, or clinical documentation that includes the following information (IF AVAILABLE):
Wound location(s), size(s), and duration. Previous treatments that have been tried. Labs/imaging in the past 2 months (Prealbumin, A1C, and vascular studies.)

*Please inform us if patient has a history of the following: ___ MRSA ___ VRE ___ ESBL ___ C. Diff

HBOT ONLY

If certain criteria are met MEDICARE and other third party payors now cover Hyperbaric Medicine (HBO) for the following indications. Please check the proper diagnosis and supporting data to justify therapy. Patient must present with all supporting criteria for the given diagnosis to qualify for HBO therapy.

☐ Diabetic Non-Healing Wound
- ☐ Diabetic Type I or Type II
- ☐ Standard wound care for 30 days.
- ☐ Wound is Wagner Grade 3 or > (example: abscess.)

☐ Peripheral Arterial Insufficiency Ulcer(s)
- ☐ Embolism or Thrombosis
- ☐ Has been maximally revascularized (angioplasty or surgical revacularization), if possible.
- ☐ Persistent hypoxia and/or wound failure remains after attempts at maximum revascularization.

☐ Osteoradionecrosis of the Mandible
- ☐ Date of previous radiation treatment_____.
- ☐ Number of Previous Rads _____, if available.

☐ Progressive Necrotizing Infection
- ☐ Tissue biopsy positive for both aerobic and anaerobic infection.

☐ Crush Injury and/or Suturing of Severed Limb(s)
- ☐ Ciculation is compromised to the effected extremity or body part and/or...
- ☐ Loss of function, limb, or life is threatened.

☐ Failed Skin Graft or Flap
- ☐ Physician's clinical judgment and documentation support specific failing site.
- ☐ Measurement of failing site _____.
- ☐ Fraft/flap site _____.

☐ Osteomyelitis (Refractory)
- ☐ Patient has localized or diffuse osteomyelitis.
- ☐ Patient has failed to respond to surgical debridement and/or a 4-6 weeks course of appropriate antibiotics.
- ☐ Patient has a positive radiological examination.

☐ Soft Tissue Radionecrosis
- ☐ Patient has radiation cystitis or radiation proctitis.
- ☐ Patient has radionecrosis of other ody site (e.g. chest wall, neck , extremity).
- ☐ Radionecrosis site: _____.
- ☐ Date of previous radiation tratment _____.
- ☐ Number of previous Rads _____, if available.

Physician's Name: _____
Physician's Signature: _____
Phone Number: _____
Date: _____ Fax Number: _____