Baptist Wound Care & Hyperbaric Medicine

Patient Referral Form

Wound Care and Hyperbaric Medicine Center

Date: ______________________

Referring Physician: ______________________

Practice: ______________________ **NPI#:** ______________________

Phone#: ______________________ **Fax#:** ______________________

Referral Coordinator Name, Phone (*REQUIRED): ______________________

Patient Name: ______________________

Patient Phone: ______________________ **Patient DOB:** ______________________

Primary Insurance: ______________________ ****WAS PRIOR AUTH OBTAINED?** ______________________

Secondary Insurance: ______________________

Reason for Referral:

- ☐ Wound care evaluation & treatment ONLY
- ☐ Hyperbaric evaluation & treatment ONLY
- ☐ Wound care evaluation & treatment PLUS Hyperbaric Evaluation

Please check all that apply:

- ☐ Acute peripheral arterial insufficiency
- ☐ Arterial ulcer
- ☐ Decubitus ulcer
- ☐ Insect bite
- ☐ Peripheral vascular disease
- ☐ Radiation proctitis
- ☐ Acute traumatic peripheral ischemia
- ☐ Cellulitis
- ☐ Diabetic wound lower extremity
- ☐ Osteoradionecrosis
- ☐ Other ______________________
- ☐ Post-operative wound
- ☐ Soft tissue radionecrosis
- ☐ Venous stasis ulcer
- ☐ Actinomycosis
- ☐ Wound dehiscence
- ☐ Compromised or failed flap/graft
- ☐ Hemorrhagic cystitis
- ☐ Osteomyelitis / Chronic Refractory Osteomyelitis
- ☐ Radiation injury (other)
- ☐ Thermal burn
- ☐ Other ______________________

The following information MUST be included with the referral in order to be processed:

- **Patient Demographics & Insurance Information**
- **RECENT Clinical Notes regarding the wound(s)**
- **Copy of the Patient's Insurance Card(s) if available**

Please fax this completed form to: 904-376-3441

Thank you for your referrals!