CAROLINAEAST MEDICAL CENTER

WOUND HEALING & HYPERBARIC SERVICES

2007-C Neuse Boulevard
New Bern, NC 28560
PHONE: 252-634-6360
FAX: 252-634-6364

Referral Form

Please evaluate and treat this patient at Wound Healing & Hyperbaric Services

Appointment Date: _____ Time:_____

PLEASE FAX ALL REFERRALS TO 252-634-6364

Referral Form

PATIENT INFORMATION

_____
FULL NAME

_____
DATE OF BIRTH (MM/DD/YYYY) GENDER

_____
STREET ADDRESS

_____
CITY/STATE/ZIP

_____
HOME PHONE WORK PHONE

_____
SOCIAL SECURITY NUMBER

PATIENT MEDICAL INFORMATION

ONSET: _____ # OF WOUNDS: _____

LOCATION: _____

_____

POST/ OP DIABETIC AMBULATORY SNF O2

_____

Dx Code:_____

Is patient competent to consent and provide medical history? Yes or No

If No, an appropriate representative must attend first appointment for consent/history.

REQUIRED DOCUMENTS

PLEASE PROVIDE PHOTO ID, INSURNACE CARD, MEDICATION LIST AND PRIOR TEST RESULTS

PROVIDER INFORMATION

_____
REFERRING PROVIDER:

_____
PCP:

_____
ADDRESS

_____
PHONE FAX

INSURANCE INFORMATION

_____
Type of Insurance (If Medicaid, Tricare or VA, must show authorization #)

_____
Authorization #

_____
Insurance #1 Group #

_____
Subscriber Name and Date of Birth

REASON FOR REFERRAL

WOUND CARE *HBO EVAUATION*

Complete by: _____