## OUTPATIENT REFERRAL REQUEST – ADVANCED WOUND CENTER

### Referring Physician

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th>Phone: ( )</th>
<th>FAX: ( )</th>
</tr>
</thead>
</table>

### Services Requested

- [ ] Wound care evaluation with follow-up treatment
- [ ] Wound care evaluation with recommendations only
- [ ] Hyperbaric Oxygen Therapy (HBOT) Evaluation/Treatment

<table>
<thead>
<tr>
<th>HBOT Diagnosis:</th>
<th>TCOM evaluation for: (circle one or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amputation level</td>
</tr>
</tbody>
</table>

### Patient History

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Phone Number: ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound Location:</td>
<td>Wound acquired:</td>
</tr>
</tbody>
</table>

- [ ] Foot
- [ ] Leg
- [ ] Left
- [ ] Right
- [ ] Other

<table>
<thead>
<tr>
<th>Chief Complaint:</th>
<th>Does Patient have Diabetes?</th>
</tr>
</thead>
</table>

### Wound Treatment History

- [ ] Surgical Debridement
- [ ] Revascularization
- [ ] Offloading

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
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</tbody>
</table>

### Please Fax (978) 825-5945 or Send Any of the Following Information:

- **HISTORY AND PHYSICAL**
- **PATHOLOGY REPORT**
- **EKG**
- **OPERATIVE REPORT**
- **CULTURES**
- **LABS (CBC / SMA 20 / SED RATE / HGB A1C)**
- **RADIOLOGY (X-RAY / BONE SCAN / CHEST X-RAY)**
- **LIST OF MEDICATIONS (as known by office)**

### Please Instruct the Patient on the Following:

- To bring all medications or a list of them to their appointment
- To bring insurance cards and any other payor information
- To bring any medical records, as requested above
- The evaluation will take approximately 2 hours
- Arrive 15 minutes early in order to complete the registration process
- If patient is too debilitated to sign authorization permits, please instruct a family member, preferably one with power of attorney, to accompany patient

### MD Signature: ___________________________ Date: ___________ Time: ________

**Urgent / Emergent Referrals Require Physician to Physician Contact**

For Changes or modifications to this form, please contact the Forms Committee

NSMC Form # 293  Forms Committee Approved: 08/01/13  Created / Revised: August 2013

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