Lakewood Ranch Medical Center
Center for Wound Healing and Hyperbaric Medicine

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Express Referral Form

PLEASE RETURN COMPLETED FORM VIA FAX

Date: _____

Referring physician, practice: _____

Phone: _____ Fax:_____

Patient Information

Name:_____ Phone: _____

Primary (Secondary) insurance: _____

Referral Information

- ☐ Evaluation and treatment: Both specialized wound care and hyperbaric medicine
- ☐ Evaluation and treatment: Specialized wound care only
- ☐ Evaluation and treatment: Hyperbaric medicine only

{Affix Patient Label Here}

Wound type:

☐ Acute peripheral arterial insufficiency	☐ Acute traumatic peripheral ischemia	☐ Actinomycosis
☐ Arterial ulcer	☐ Cellulitis	☐ Wound dehiscence
☐ Decubitus ulcer	☐ Diabetic ulcer (any)	☐ Compromised flap or graft
☐ Insect bite	☐ Osteoradionecrosis	☐ Hemorrhagic cystitis
☐ Peripheral vascular disease	☐ Post-operative wound	☐ Osteomyelitis
☐ Radiation proctitis	☐ Soft-tissue necrosis	☐ Pressure ulcer
☐ Trauma	☐ Venous ulcer	☐ Thermal burn
		☐ Other:_____

Additional comments: _____

_____

Please send a copy of patient's **History and Physical,** a recent **Progress Note**, most recent **Labs**, **Vascular Studies, X-ray/imaging**, current **Problem and Medication List**, and a current **Face Sheet** when faxing referral.