

WakeMed Wound Care Center - Cary

210 Ashville Avenue, Suite 420

Cary, NC 27518

Phone: (919) 350-4515 Fax: (919) 235-1308

WOUND AND HYPERBARIC REFERRAL FORM						
PATIENT DEMOGRAPHICS (may attach face sheet instead)						
Today's Date:				Patient DOB:		
Patient Name:				□M □F		
Primary Care Physic	ian:			Phone:		
Address:		City:			State:	Zip:
Phone: Alternate Phone:						
PATIENT INSURANCE INFORMATION (may attach face sheet instead)						
Primary:				ID#:	Group#:	
Phone:						
Secondary:				ID#:	Group#:	
Phone:						
Is patient in a nursin	g home?	□ No	☐ Yes	Facility name:		
Is patient receiving h	nome health care?	□ No	☐ Yes	Agency name:		
Auto or workers' co	mpensation claim?	□ No	☐ Yes	Date of injury:		
REFERRAL REASON Wound Location Wound Location						Wound Location
☐ Arterial/ischemic ulcer			Compromised skin graft or flap			
☐ Diabetic foot ulcer ☐ Crush injury						
☐ Pressure injuries/ulcer ☐ Non-healing, post-surgical wound						
☐ Venous ulcer			☐ Traumatic wound			
☐ Late effects of radiation ☐ Other						
☐ Hyperbaric oxygen therapy			Indication:			
ADDITIONAL COMMENTS:						
Is patient on antibiotics?		□ No	☐ Yes	RX name:		
Is patient on blood thinners?		□ No	☐ Yes	RX name:		
REFERRER INFORMATION						
Referral Source:	☐ Physician	☐ Discl	narge Planner	☐ Nursing Home	□ Nu	urse Practitioner
	☐ Home Health	□ PA		☐ Other:		
Referrer Name:		Phone:		Fax:		
Referral Office Contact:			Phone: Ext:			
DI FASE INCLUDE ALL DELEVANT MEDICAL DECORD DOCUBES NOTES WITH DIAGNOSIS LAD TESTS AND IMAGING DESILITS						

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