FHN
The Center for Wound Healing at FHN Memorial Hospital

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FAX: 815.599.7420 **PHONE: 815.599.7410**

WOUND AND HYPERBARIC REFERRAL FORM

PATIENT DEMOGRAPHICS *(may attach face sheet instead)*

Today's Date:		Patient DOB:	
Patient Name:		❑M ❑F	
Primary Care Physician:		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 nursing home?	❑ No ❑ Yes	Facility name:	
Is patient receiving home health care?	❑ No ❑ Yes	Agency name:	
Auto or workers' compensation claim?	❑ No ❑ Yes	Date of injury:	

REFERRAL REASON	***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	❑ Discharge Planner	❑ Nursing Home	❑ Nurse Practitioner
	❑ Home Health	❑ PA	❑ Other:	

Referrer Name:	Phone:	Fax:
Referral Office Contact:	Phone:	Ext:

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.

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