NORMAN REGIONAL
Oklahoma Wound Center

Wound Care & Hyperbaric Referral Form

Referral Line: (405) 307-6955
Fax: (405) 307-6957

O **Wound Care Evaluation/Treatment** O **Hyperbaric Oxygen Therapy**

Patient Name:_____ Diagnosis:_____

Referring Physician (Print):_____ Phone:(_____)_____

Date of Referral:_____ Fax:(_____)_____

GENERAL INFORMATION:

If face sheet is available, please attach a copy. If no face sheet is available, please provide the following demographic information: O **Please mark if face sheet is attached.**

DOB:_____/_____/_____ Patient Phone:(_____)_____

Patient Address:_____
Number Street Apt. City State Zip

Insurance: Primary:_____ Phone:(_____)_____

Secondary:_____ Phone:(_____)_____

OTHER INFORMATION (Please fill in the following):

Primary Care Physician:_____ PCP Phone:(____)_____

Diabetic: O Yes O No Home Health Services: O Yes O No HH Company:_____

# of Wounds:_____ Wound Site:_____ Wound Duration:_____

Type:

O Diabetic Ulcer O Venous Wound O Trauma

O Pressure Ulcer O Arterial Wound O Other_____

ADDITIONAL INFORMATION (Please send if this information is available):

- O Current History and Physical/Most Recent Office Notes, Operation Notes
- O List of Current Medications, Dressings, Wound Care, etc.
- O Recent Lab/Culture Results, Radiology Reports, EKG, Vascular Studies, Implantable Devices