Randolph Health
Wound Care &
Hyperbaric Center

# Express Referral Form

PLEASE RETURN COMPLETED FORM VIA FAX
Fax Number: 336-318-4172

Date: _____

Referring physician, practice: _____

Phone: _____ Fax:_____

## Patient Information

Name: _____ DOB: _____ Phone: _____

For Your Convenience Please Forward Patient(s) Face Sheet

**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

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: _____

_____