Center for Wound Care and Hyperbaric Medicine
Member of the Heywood Healthcare Family

PATIENT REFERRAL INFORMATION

DEMOGRAPHICS:

Patient Name ____ Date_____/_____/___________

Patient Date of Birth______/______/___________

Patient Address____

Patient Phone # (_______) _____________________ Alternate Phone # (______) ______________________________

Patient's Primary Care Physician___________________________________**NPI#**_________________________________

Primary Care Physician's Office Phone# (_______) __________________ Fax# (________) _______________

INSURANCE INFORMATION

Reason for Referral____

Primary Insurance____ Policy #_____________________________

Secondary Insurance______________________________________ Policy#______________________________

Referring Physician ____ NPI #______________________________

Referring Physician Address____

Referring Physician Office Phone #______________________________Referring Physician Fax #______________

Is Patient Ambulatory? Yes______No_______

Will Patient need Interpreter Services? No_____ Yes, if so what language_______________________________

Is Patient able to consent to treatment? Yes_______ No_________

Please include copies of patient's ***Medication list, Past Medical History, History of the Wound, Recent test results pertaining to the wound including any Vascular Studies, Lab Results, and X-Rays when faxing referral.***

FAX ALL INFORMATION TO (978) 669-5695

Thank you,

Wound Care Center Staff

Center for Wound Care and Hyperbaric Medicine | 242 Green Street | Gardner, MA 01440 | (978) 669-5690 | www.heywood.org