

TREATMENT REFERRAL FORM

Healing under pressure in a mono-place environment, tailored to your patient's needs.

NORTH CAROLINA HYPERBARICS, LLC

3035A Boone Trail Extension
Fayetteville, NC 28304

910-920-1165 Fax: 910-425-5178

Consult

Wound Care

Hyperbaric Oxygen Therapy

<i>(Patient Name)</i>		<i>(Date of Birth)</i>	
<i>(Address)</i>		<i>(City)</i>	<i>(State)</i> <i>(Zip)</i>
<i>(Home Phone)</i>		<i>(Other Phone)</i>	
<i>(Primary Insurance Carrier)</i>	<i>(Primary Insurance ID #)</i>	<i>(Secondary Insurance Carrier)</i>	<i>(Secondary Insurance ID #)</i>
<i>(Referring Physician)</i>		<i>(Physician Phone)</i>	<i>(Physician Fax)</i>

***** PLEASE FAX COPIES OF PATIENTS INSURANCE CARDS WITH THIS FORM *****

Physician Statement

The above named individual is currently under my medical care. I have recommended an evaluation of this patient for wound care/hyperbaric oxygen treatment for the indication checked below; which may be medically necessary for optimal care of the condition for which I have consulted North Carolina Hyperbarics.

- | | |
|---|---|
| <input type="checkbox"/> Diabetic Wound | <input type="checkbox"/> Compromised Wound |
| <input type="checkbox"/> Failure of Skin Graft / Flap | <input type="checkbox"/> Radiation Tissue Damage / Soft Tissue Radio-necrosis |
| <input type="checkbox"/> Osteomyelitis, Chronic | <input type="checkbox"/> Osteoradionecrosis |
| <input type="checkbox"/> Necrotizing Soft Tissue Infections | <input type="checkbox"/> Crush / Compartment Syndrome |
| <input type="checkbox"/> Other _____ | |

Physicians Signature

Date

Thank you for allowing us to participate in the care of your patient.

Deon F. Faillace, MD

F. Andrew Morfesis, MD, F.A.C.S

Helen Gelly, MD