WOUND CARE
HYPERBARICS REFERRAL

Date: _____ Referral for: ☐ Wound Management ☐ Hyperbarics

Referring physician or facility: _____

Office/facility contact: _____ Phone: _____ Fax: _____

Patient name: _____ DOB: _____

Address: _____

Home phone: _____ Work Phone: _____ Cell: _____

Other contact information: _____

Patient needs: ☐ Walker/cane ☐ Wheelchair ☐ Stretcher ☐ Aide ☐ _____

Wound site: ☐ Right leg ☐ Above knee ☐ Below knee ☐ Ankle/foot
☐ Left leg ☐ Above knee ☐ Below knee ☐ Ankle/foot

Open wound: ☐ Yes ☐ No Other: _____

_____

Primary Insurance: _____

Secondary insurance: _____

Authorization Required: _____

Please fax patient information including H&P, progress notes, demographics, insurance authorization if required, current medication list, recent labs to 321.837.1718

_____

_____

Thank you for your referral.

Health First Wound Care & Hyperbaric Center
5191 Babcock Street NE
Palm Bay, FL 32905

Phone: 321.434.1788
Fax: 321.837.1718

Health First Wound Care & HYPERBARICS

Holmes Regional Medical Center, Melbourne, Florida
Palm Bay Hospital, Palm Bay, Florida
Viera Hospital, Viera, Florida