Hyperbaric Requisition

Saint Agnes Medical Center
7015 N. Maple Ave, Suite 101
Fresno, CA 93720
Phone 559.450.3456
Fax 559.450.5471

106500-1155 (4/08)

604

Patient's Name _____ DOB _____

Diagnosis _____ Phone _____

Patient's Insurance _____

Contact Person In Referring Office _____

Clinical Information:
- ☐ Diabetic Ulcer
- ☐ Failing Skin Graft/Flap
- ☐ Acute Traumatic Ischemia/Crush Injury
- ☐ Chronic Acute Osteomyelitis
- ☐ Osteoradionecrosis
- ☐ Soft Tissue Radionecrosis
- ☐ Gas Gangrene
- ☐ Other _____
- ☐ Progressive Necrotizing Infection

Location:
- ☐ Left
- ☐ Right
- ☐ Head/Neck
- ☐ Upper Extremity
- ☐ Axilla
- ☐ Abdomen
- ☐ Hip/Buttocks
- ☐ Lower Extremity
- ☐ Foot/Ankle
- ☐ Other _____

History:

- Describe Current Treatment: _____
- Length of Current Treatment: _____ week(s).
- Has the patient had a Vascular Assessment: ☐ No ☐ Yes (please fax results)

  If so, describe: _____
- Has the wound(s) been cultured: ☐ No ☐ Yes Where _____
- Has the patient had diabetic counseling: ☐ No ☐ Yes
- Does the patient have any related Imaging: ☐ No ☐ Yes (please fax results)

Is the patient currently on Antibiotics: ☐ No ☐ Yes, type: _____

Additional Instructions: _____

_____

_____

Please fax Referral, Most Recent H&P, List of Medications, Patient Demographics, and Copy of Insurance Cards to 559.450.5471. Thank you for your referral.

Referring Physician _____ Office Telephone _____

Physician's Signature _____ Date _____