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Wound, Ostomy & Hyperbaric Center

Saint Agnes Medical Center
7015 N. Maple Ave., Suite 101, Fresno, CA 93720
Phone 559.450-3456 Fax 559.450.5471

REFERRAL FORM

106500-1120 (4/08)

Patient's Name _____ DOB _____

Diagnosis _____ Phone _____

Patient's Insurance _____

Contact Person In Referring Office _____

Patient was last seen in Referring Office on _____

Type of Wound:
- ☐ Diabetic Ulcer
- ☐ Pressure Ulcer Stage _____
- ☐ Surgical Wound
- ☐ Trauma Wound
- ☐ Venous Stasis Ulcer
- ☐ Other _____

Date Wound/Injury Occurred: ____/____/_____ ☐ Work Comp

Location:
- ☐ Ankle
- ☐ Arm
- ☐ Abdomen
- ☐ Back
- ☐ Buttock
- ☐ Foot
- ☐ Heel
- ☐ Hip
- ☐ Lower Extremity
- ☐ Other _____

Who is currently treating the wound:
- ☐ Self
- ☐ Caregiver
- ☐ Home Health: _____
- ☐ SNF: _____
- ☐ Other: _____

History:

- Describe Current Treatment: _____
- 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 of Ostomy:
- ☐ Colostomy
- ☐ Urostomy
- ☐ Ileostomy
- ☐ Surgical Procedure

Additional Instructions: _____

_____

_____

Referring Physician (please print) _____ Office Telephone _____

Physician's Signature _____ Date/Time: _____

Please fax Referral, Most Recent H&P, List of Medications, Patient Demographics, and Copy of Insurance Cards to 559.450.5471