The Wound Treatment Center
of East Alabama Medical Center

PATIENT REFERRAL FORM

Patient Name: ____ DOB: _______________________

Address: ____

City: ____ State: _______ Zip: _______________________

Primary Phone Number: __________________________________ SS#: _____________________________

Insurance: _________________________________ Contract#: ______________ Group#: _____________

Policy Holder: ____ DOB: ______________________

Reason for Referral *(insurance referral authorizations should be faxed with this request):*

- ☐ Evaluate Wound(s) and Treat as Appropriate
- ☐ Wound Care Consultation
- ☐ Evaluate Tissue Oxygenation (TCOM) at Wound/Surgical Sites as Indicated
- ☐ Evaluate for Hyperbaric Oxygen Treatment

**Please send patient demographics, insurance information (including referral authorization) along with current H&P, labs, radiology reports, most recent office note including wound location, duration, current treatment and any other pertinent clinical information (A1c if patient has diabetes).

Referring Physician's Printed Name: ____

Referring Physician's Signature ___________________________ Date: _____________ Time: _________

Office Contact: ____ Phone: ___________________________

To refer a patient to the Wound Treatment Center:

1. **FAX referral with patient information to Clinic (334) 528-2320**
2. **Call Clinic to SCHEDULE patient appointment: (334) 528-5930**

Thank you for choosing the Wound Treatment Center
Located on the campus of East Alabama Medical Center

2000 Pepperell Parkway, Building 190 - Opelika, AL 36801 - (334) 528-5930