Wound Healing Center
Columbus Regional Healthcare System

Referral Worksheet

800 Jefferson Street, Ste. 101
Whiteville, NC 28472
Phone: 910-640-4070
Fax: 910-640-4626

Date: .....

Referring Physician: ..... Ph: .....

Patient: ..... Ph: .....

Address: .....

City: ..... State: ..... Zip: .....

DOB: ..... SSN: .....

Insurance: ..... Cert #: .....

Group #: ..... Authorization #: .....

Primary Care Physician: ..... Ph: .....

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Diabetic? ☐ Yes ☐ No Medicare Part B Eligible? ☐ Yes ☐ No ☐ N/A

To schedule an appointment we should contact: ☐ Office ☐ Patient

Type & Location of Wound to be Treated

☐ Diabetic Ulcer ☐ Venous Ulcer ☐ Pressure Ulcer ☐ Surgical Wound

☐ Traumatic ☐ Non-Healing (Other)

Loc: .....

Wound Measurement _____CM _____CM

Duration of Wound(s)

☐ Less than 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ 6-12 Months

☐ Greater than 1 Year

Hyperbaric Oxygen Indications

☐ Lower Extremity Diabetic Ulcer ☐ Soft Tissue Radiation Necrosis/Radiation Cystitis

☐ Chronic Refractory Osteomyelitis ☐ Compromised Skin Grafts

☐ Osteoradionecrosis/Bone Reabsorption