Center for Wound Care and Hyperbaric Medicine
Rhode Island Hospital
950 Warren Avenue
East Providence, RI 02914
Phone: 401-606-4325
Fax: 401-572-3964

Lifespan
Delivering health with care.

New Patient Referral Form

Patient Name: _____

DOB: _____

Date: _____

Referring Physician: _____

Enter ICD-10: _____**Or** Choose Unspecified Open Wound of:

☐ Head(S01.90) ☐ Neck(S11.90) ☐ Breast(S21.00) ☐ Abdomen(S31.10)

☐ Upper Arm(S41.10) ☐ Hand(S61.40) ☐ Back/Pelvis(S31.00)

☐ Buttocks(S31.809) ☐ Hip(S71.00) ☐ Lower Leg(S81.80) ☐ Foot(S91.30)

Please select the reason for your referral:

1. **Comprehensive Wound Assessment for Evaluation of:**

   Wound Type and location: _____

2. **Hyperbaric Oxygen Therapy for Treatment of which the following:**

   ☐ Diabetic Wounds of Lower Extremities: Wagner Grade III, IV, V
   ☐ Chronic Refractory Osteomyelitis
   ☐ Soft Tissue Radionecrosis
   ☐ Osteoradionecrosis of the Mandible
   ☐ Compromised Flaps/Graft

Please fax the items below to (401) 572-3964. Kindly take note that an incomplete referral will delay scheduling.

- Demographic Information
- History and Physical with current medication list
- Most recent progress note(s)
- Any tests or lab work specific to the wound
- Referral Insurance Authorization Confirmation (if required by insurance/workers comp)