

PATIENT REFERRAL FACSIMILE TRANSMITTAL



Ashland Community Hospital

To: The Center for Wound Healing and Hyperbaric Medicine
FAX: (541) 488-7436

FROM: _____ PHONE: _____
DATE: _____ FAX: _____



Patient Name: _____ Patient D.O.B. _____
Patient SS#: _____
Patient Address: _____ Patient Phone: _____

Primary Diagnosis/Problem: _____
Additional Pertinent Patient Information (i.e.: dementia, ambulatory, caregiver, etc): _____

Primary Care Physician: _____ Phone: _____
PATIENT PRIMARY INSURANCE: _____

Please include the following documentation: Current History and Physical, List of current medications, wound care chart notes, recent labs including therapeutic drug levels

IF the patient is being referred as a possible candidate for Hyperbaric Therapy please include: 2 view Chest X-Ray no more than 3 months old, EKG if over 40 and/or cardiac history, CBC and Chem panel.

Confidentiality Notice: This facsimile transmission is intended for the address named above, only. It contains information that is privileged, confidential or otherwise protected from use and disclosure. If you are not the intended recipient, you are hereby notified that any review, disclosure, copying or dissemination of this transmission, or other use is strictly prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for its return. Thank you for your cooperation.

Center for Wound Healing & Hyperbaric Medicine
280 Maple Street, Ashland, OR 97520
Phone: (541) 201-4420