LOUISIANA ADVANCED LIMB SALVAGE
WOUND CARE HYPERBARICS
901 WILSON ST. LAFAYETTE, LA 70503
337-889-5726 FAX: 337-889-5546

PATIENT REFERRAL FORM

PATIENT INFORMATION					
Last Name		First Name		Middle Initial	
Date of Birth	Age	___Male ___Female	Social Security #	Home Phone ( )	Cell Phone/ Other ( )
Street Address	Apartment #	City	State	Zip	

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
Insurance Company Name	Insurance Phone #	Insurance Company Name	Insurance Phone #
Relationship to patient	Authorization #	Relationship to patient	Authorization #
Group #	Policy #	Group #	Policy #

PHYSICIAN INFORMATION		
Date of Referral:	Referring Physician/ Provider	Office #

Alternate Contact Name and Number: _____

Is patient in a Nursing/ Rehab Facility? _____ If Yes, which facility _____

is patient a resident or in a skilled bed? _____

Home Health _____ Pharmacy _____

Is patient alert and oriented? _____ Can patient sign own consents and give a medical history? _____

Is patient diabetic or on dialysis? _____ If so, IDDM NIDDM MEDS UNKNOWN

Dialysis Schedule _____

WOUND LOCATION _____ ICD-10. _____

NUMBER OF WOUNDS _____

PLEASE FAX THE FOLLOWING TO 337-889-5546

CURRENT H&P, MARS, DRIVERS LICENSE, INSURANCE CARDS, CURRENT LABS AND ARTERIAL/ VENOUS STUDIES (PAST 3 MONTHS)

APPOINTMENT SCHEDULED FOR _____@ _____

Permanent Part of Medical Record

WOUND CARE CENTER PATIENT REFERRAL FORM