Mass General Brigham
Salem Hospital

Patient Identification Label

OUTPATIENT REFERRAL REQUEST – ADVANCED WOUND CENTER

REFERRING PHYSICIAN		
Physician Name:	Phone: ( )	FAX: ( )

SERVICES REQUESTED		
☐ Wound care evaluation with follow-up treatment		
☐ Wound care evaluation with recommendations only		
☐ Hyperbaric Oxygen Therapy (HBOT) Evaluation/Treatment | HBOT Diagnosis:		
☐ TCOM evaluation for: (circle one or more)	Amputation level	Vascular assessment

PATIENT HISTORY	
Patient Name:	Phone Number: ( )
Wound Location: ☐ Foot ☐ Leg ☐ Left or ☐ Right	Chief Complaint:
☐ Other:	
Wound acquired:	Does Patient have Diabetes?

WOUND TREATMENT HISTORY			
☐ Surgical Debridement	Date:	☐ Skin Graft	Date:
☐ Revascularization	Date:	☐ Antibiotics	Date:
☐ Offloading	Date:	☐ Amputation	Date:

PLEASE FAX (978) 825- 5945 OR SEND ANY OF THE FOLLOWING INFORMATION:

- HISTORY AND PHYSICAL
- PATHOLOGY REPORT
- EKG
- OPERATIVE REPORT
- CULTURES
- LABS (CBC / SMA 20 / SED RATE / HGB A1C)
- RADIOLOGY (X-RAY / BONE SCAN / CHEST X-RAY)
- LIST OF MEDICATIONS (as known by office)

PLEASE INSTRUCT THE PATIENT ON THE FOLLOWING:

- *To bring all medications or a list of them to their appointment*
- *To bring insurance cards and any other payor information*
- *To bring any medical records, as requested above*
- *The evaluation will take approximately 2 hours*
- *Arrive 15 minutes early in order to complete the registration process*
- *If patient is too debilitated to sign authorization permits, please instruct a family member, preferably one with power of attorney, to accompany patient*

MD Signature: _____ Date: _____ Time: _____

URGENT / EMERGENT REFERRALS REQUIRE PHYSICIAN TO PHYSICIAN CONTACT