

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



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)