SUDBURY
HYPERBARICS & WOUND CARE

2009 Long Lake Road, Unit 1B
Sudbury, ON P3E 6C3

HBOT REFERRAL FORM

PATIENT INFORMATION

Full Name: ______________________ DOB: ______________________
First Last DD/MM/YYYY

Email Address: ______________________ Phone Number: ______________________

Address: ______________________ Health Card # : ______________________

Primary Care Provider: ______________________ Current MRP Wound Care : ______________________

Wound Care nurse/NSWOC RN: ______________________

REASON FOR REFERRAL

- ☐ Chronic/Problem Wound
- ☐ Diabetic Foot Ulcer
- ☐ Non-healing Surgical Wounds
- ☐ Refractory Osteomyelitis
- ☐ Compromised Flaps/Grafts
- ☐ Sudden Sensorineural Hearing Loss
- ☐ Crush Injury/Compartment Syndrome
- ☐ Delayed Radiation Injury
- ☐ Frostbite/Thermal Burns
- ☐ Other: ______________________

HISTORY

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PLEASE INCLUDE ALL OF THE FOLLOWING INFORMATION WITH YOUR REFERRAL (IF AVAILABLE):

- Relevant Diagnostic Imaging and/or Vascular Studies (CT, ECHOs, CXR, ABIs)
- Recent Bloodwork Including: HbA1C, CBC, ESR/CRP
- List of Medications and Allergies
- Past Medical/Surgical History/Allergies/Medications
- Recent Consults or Follow Up Notes
- Specialist Reports Including: Cardiology, Respiratory, ENT, Dermatology, Ortho/Vascular Surgery)

REFERRING PROVIDER INFORMATION

Name: ______________________ Tel: ______________________

Billing Provider #: ______________________ Fax: ______________________

Provider License #: ______________________ Date: ______________________

Signature: ______________________