Western Maryland Health System
Wound & Hyperbaric Center
New Referral Form

Name: ____ DOB: ________________

Address: ____

Telephone: ____________________ Alternative Telephone: __________________

Insurance: ____

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Referring Provider: _________________ Office Contact Name: __________________

Referring Provider Telephone: _____________________ Patient Aware of Appt. Y / N

Reason for Referral: ____

Duration of Wound: ____

Previous Patient Here: Y / N   Is Patient Diabetic: Y / N

Currently on Antibiotics: Y / N   Patient: Ambulatory / Wheel Chair / Stretcher

- Nursing Home Referrals- Please have POA available if patient is unable to sign consent
- All offices please send current Medication List, Most Recent Office Note and any Testing Reports (ie. Cultures, X-ray, etc.)

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