Department of Wound Care & Hyperbaric Medicine

Backus Outpatient Care Center
111 Salem Turnpike
Norwich, CT 06360
ph: (860) 425-8700
fax: (860) 889-4708

Physician Order / Referral Form

Patient Information:

Name: _____ DOB: _____ Today's Date: _____

SSN: _____ Sex: M F Marital Status: _____

Address: _____

Telephone (Home): _____ (Work): _____ (Cell): _____

Primary Care Physician: _____ Referring Physician: _____

Diagnosis: _____ Office Phone #: _____

Reason For Referral:

Clinical Signs & Symptoms: _____

☐ Wound Care / Ostomy Care
Evaluate & Treat _____
Nurse Visit Only _____

☐ Wound Care / Ostomy Care Orders for Nurse Visit: _____
Frequency : _____ per week
Duration: _____ per week

☐ Evaluate for Hyperbaric Medicine (includes TCPO2) ☐ TCPO2 Only

Insurance Information:

Primary Ins Co: _____ Secondary Ins Co: _____

Address: _____ Address: _____

Policy or ID #: _____ Policy or ID #: _____

Relationship of insured: _____ Relationship of insured: _____

Referral Authorization #: _____

Physician Signature: _____