South Florida Baptist Hospital
BayCare Health System

THE CENTER FOR WOUND CARE AND HYPERBARIC MEDICINE

PLEASE FAX COMPLETED FORM AND SIGNED PHYSICIAN ORDER BELOW TO (813) 757-8521

PLEASE INCLUDE COPY OF PATIENT'S ID & INSURANCE CARDS IF AVAILABLE

IF YOU ARE THE PRIMARY CARE PHYSICIAN PLEASE INCLUDE COPY OF AUTHORIZATION IF REQUIRED BY PATIENT'S INSURANCE

Date: _____

Patient Name: _____ SSN: _____ DOB: _____
Address: _____ Phone: _____
Subscriber Employer: _____

Referring MD: _____ Phone: _____ Fax: _____
Primary Care MD: _____ Phone: _____ Fax: _____

Insurance 1: _____ Policy #: _____
Auth/Referral#: _____ **Eff Date:** _____ **Exp Date:** _____ **# of Visits Authorized**: ____
Ins Phone: _____ Subscriber:_____ Relationship:_____
Subscriber DOB:_____ Subscriber SSN: _____

Insurance 2: _____ Policy #: _____
Auth/Referral#: _____ **Eff Date:** _____ **Exp Date:** _____ **# of Visits Authorized**: ____
Ins Phone: _____ Subscriber:_____ Relationship:_____
Subscriber DOB:_____ Subscriber SSN: _____
Comments: _____
_____
_____
_____

PHYSICIAN'S ORDER:

❒ WOUND CARE EVALUATE AND TREAT ❒ HYPERBARIC EVALUATE AND TREAT

DIAGNOSIS: _____

ICD 9 CODES: _____

WOUND LOCATION_____

OTHER:_____

_____

_____ _____
PHYSICIAN'S SIGNATURE **DATE**

THANK YOU FOR YOUR REFERRAL. PLEASE CALL WITH ANY QUESTIONS.
(813) 757-1280

For Department Use Only