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EVALUATE AND TREAT: *Check All That Apply*

- Wound Care Management Hyperbaric Evaluation

===== PATIENT INFORMATION =====

First Name _____ Last Name _____

Phone Number _____ Insurance _____

- | | |
|--|--|
| <input type="checkbox"/> Refractory Osteomyelitis | <input type="checkbox"/> Trauma Wound/Crush Injury |
| <input type="checkbox"/> Compromised Flap/Tissue/Ortho. Device | <input type="checkbox"/> Diabetic Wound/Ulcer |
| <input type="checkbox"/> Radiation Damage/Bone/Skin/Cystitis/Proctitis | <input type="checkbox"/> Necrotizing Soft Tissue Infection |
| <input type="checkbox"/> Post Op Wound Infection | <input type="checkbox"/> Lower Extremity Ulcer (arterial/venous) |
| <input type="checkbox"/> Non-Healing Surgical Wound (30+ Days) | <input type="checkbox"/> Brown Recluse Spider Bite |
| <input type="checkbox"/> Sensorineural Hearing Loss | <input type="checkbox"/> Perianal Skin Complications (IBD) |
| <input type="checkbox"/> Burns (second and third degree) | <input type="checkbox"/> Pre/Post Dental Surgery on Radiated Jaw |
| <input type="checkbox"/> Retinal Artery Occlusion | <input type="checkbox"/> Intracranial abscess |

===== REFERRING CLINIC INFORMATION =====

Referred by _____ Preferred Provider/Location _____ Date _____
Authorized Signature _____ Office Phone _____

I certify that the above treatment plan is medically necessary and the services prescribed are approved by me

PLEASE ATTACH ALL RELEVANT MEDICAL NOTES AND MEDICAL HISTORY

- o Current History and Physical (completed within 30 days of evaluation)
- o List of Current Medications, Dressings, Wound Care, etc.
- o Recent Lab Results, Radiology Reports, EKG, Vascular Studies, Implantable Devices

===== ADDITIONAL INFORMATION =====

_____ ARTERIAL INSUFFICIENCY PVD NEUROPATHY
 _____ DIABETES SMOKER MALNUTRITION
 _____ IMMUNOSUPPRESSIVE THERAPY CONNECTIVE TISSUE D/O



- FOR YOUR VISIT, please:**
- Bring your insurance card and identification
 - Allow 90 minutes for initial appointment
 - Show up 20 minutes prior to appointment