ALLIANCE COMMUNITY HOSPITAL
Experience Health Caring

120 East State Street
Alliance, Ohio 44601
330.596.7940
Fax 330.829.8000

wound care ADVANTAGE

Patient Name: ____

Address: ____

City, State, Zip: ____

DOB: ____________________ Telephone #: __________________________

Referring Physician: __________________________ Podiatrist? Yes No

Telephone #: __________________________ Fax #: ____________________

Reason for Referral: [ ] Wound Care

[ ] Hyperbaric Oxygen Therapy (HBOT – patient must see wound / hyperbaric physician at least once for evaluation of appropriateness)

Diagnosis:
[ ] Diabetic Lower Extremity Wound
[ ] Compromised Flaps and/or Grafts
[ ] Chronic Refractory Osteomyelitis
[ ] Delayed Radiation Injury
[ ] Thermal Burns (non-emergent)
[ ] Crush injury (non-emergent)
[ ] Gas Gangrene
[ ] Other: DX ____

Symptoms: ____

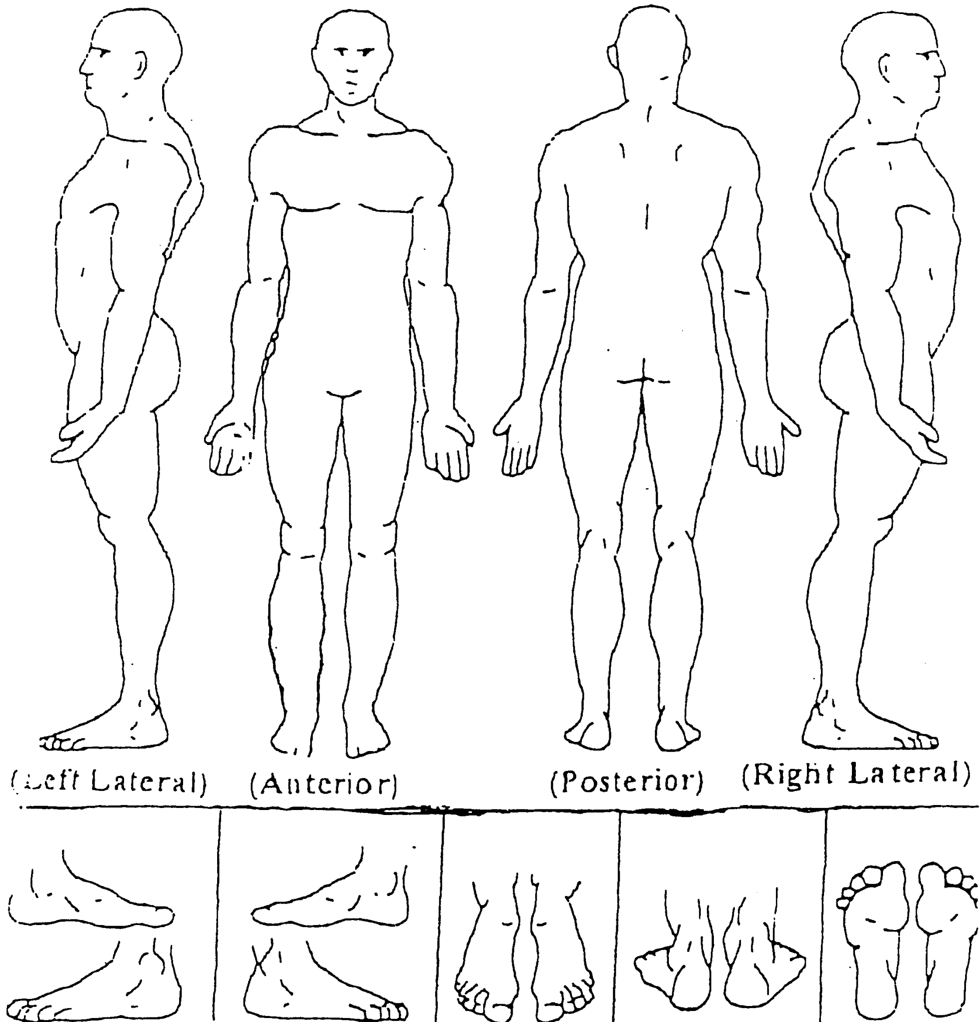
***Please fill out information on the back (fax both sides) and send the following if available to expedite care:**
1. Past H & P
2. Diagnostic Studies (X-ray, MRI, Bone Scan, Cultures and/or labwork)
3. Medication List
4. Insurance
5. Face Sheet

Physician Signature: ________________________________ Date: ____________

Patient Name: ____

DOB: _________________________________

Please indicate area and number of wounds by placing the number to the corresponding region on the body.



Wound Number	Location /Description
1	
2	
3	
4	
5	
6	
7	
8	