GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

The Center for Hyperbaric Medicine
and
Wound Healing
Referral

203.863.4505
FAX: 203.863.4511

PLEASE COMPLETE THIS REFERRAL AND FAX TO (203)863.4511. YOUR PATIENT WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT WITH DR. SZE HOAY DING. THANK YOU.

NAME: _____

DATE OF BIRTH:_____ **MALE:** _____ **FEMALE:**_____

PRIMARY PHYSICIAN: _____

CONTACT INFORMATION: (*INDICATE BEST WAY*):

HOME PHONE: _____

OFFICE PHONE: _____ **EMPLOYER:** _____

CELL PHONE: _____

E-MAIL ADDRESS: _____

FAX: _____

REASON FOR VISITS: _____

_____

Location of wound: _____

Description of problem: _____

_____

Medication List: _____

_____

_____

_____

_____

Current treatment: _____

_____

Diabetic: Yes or No **Contact Precautions: Yes or No**

Other medical conditions: _____

Recent hospitalization: Yes or No ; If YES, when: _____ **where:** _____

Able to transfer to stretcher or examination table without assistance: Yes or No

Is the patient alert/orientated to give informed consent? Yes or No

If NO, can a family member or the Power Of Attorney accompany patient? Yes or No

If NO, contact phone number _____