Wound Care & Hyperbarics

Wound Care & Hyperbarics at FirstHealth of the Carolinas are highly specialized wound care clinics that work with a patient's primary care physician to monitor, manage and treat chronic, non-healing wounds.

We use advanced wound care treatments to achieve positive outcomes for our patients.

Hyperbaric therapy can be ordered as a pivotal adjunct to wound healing for those patients at risk of losing a limb.

The goals of Wound Care & Hyperbarics are to determine and correct the underlying cause of wound development and the reason for non-healing. Our multidisciplinary approach, combined with state-of-the-art wound care products, provides the best outcome for our patients.

Pinehurst - (910) 715-5901

Raeford - (910) 878-6750

Rockingham - (910) 417-3636

PINEHURST

FirstHealth Specialty Centers Building
35 Memorial Drive • Pinehurst, NC 28374

RAEFORD

Moore Regional Hospital - Hoke Outpatient
6322 Fayetteville Road • Raeford, NC 28376

ROCKINGHAM

Moore Regional Hospital - Richmond Outpatient
925 S. Long Drive • Rockingham, NC 28379

Wound Care & Hyperbarics

Fax this completed form to: ☐ **Pinehurst** (910) 715-5902 ☐ **Raeford** (910) 878-6755 ☐ **Rockingham** (910) 417-3573

Patient Name ______________________________

Birth Date (MM/DD/YYYY) ______________ Sex ______________

Address ______________________________ City, State, ZIP ______________________________

Home Phone ______________________________ Work Phone ______________________________

PATIENT MEDICAL INFORMATION *(check all that apply)*

☐ Diabetic ☐ Ambulatory ☐ Trach ☐ Oxygen *(If yes, have patient bring 02)*

☐ Alert & Oriented ☐ Nursing Home Patient ☐ Wound VAC

Duration of Wound: ☐ 30-90 days ☐ 3-6 months ☐ 6-12 months ☐ > 1 year

Recent Test Dates: X-Ray ______________ Labs ______________ Cultures ______________

PROVIDER INFORMATION

Referring Provider ______________________________

Specialty ______________________________ NPI ______________________________

Address ______________________________ City, State, ZIP ______________________________

Work Phone ______________________________ Work Fax ______________________________

Primary Care Provider ______________________________

INSURANCE INFORMATION

Type of Insurance ______________________________ Authorization # ______________________________

(if Medicaid, Tricare or VA, must show authorization #)

1st Insurance ______________________________ Group # ______________________________

Subscriber Name ______________________________ Birth Date (MM/DD/YYYY) ______________

2nd Insurance ______________________________ Group # ______________________________

FirstHealth
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www.firsthealth.org/wound