LIMB PRESERVATION
CENTER OF EAST TENNESSEE

REFERRAL FORM

LPCETN will contact the patient to schedule their appointment. Please include the items requested below to ensure a timely onboarding process.

Please FAX to:
865.317.4357

If you have questions, contact us at:
865.770.5462
appointments@lpcetn.com

visit our website at www.lpcetn.com
NPI 1134231756

WHAT TO SUBMIT FOR YOUR REQUEST TO BE PROCESSED

___ Face Sheet
___ H&P
___ ID
___ Up to Date Medication List
___ Insurance Cards
___ Notes (i.e. A1C, wound culture, ABI, etc.)

REFERRAL REASON

___ Diabetic Foot Ulcer
___ Venous Ulcer(s)
___ Pressure Ulcer(s)
___ Non-Healing, Post-Surgical Wound(s)
___ Arterial/Ischemic Ulcer(s)
___ Notes (i.e. A1C, wound culture, ABI, etc.)
___ Post Radiation Ulcer
___ Hyperbaric Oxygen Therapy (List Indication) _____
___ Other _____
Additional Comments _____
_____

PATIENT INFORMATION

Patient Name _____ Patient DOB ___/___/_____ ___ Male ___ Female
Address _____ City _____
State _____ Zip Code _____ Primary Phone _____ Alternate Phone _____

Is patient a SNF resident? ___ Yes ___ No Facility Name _____
Is patient on antibiotics? ___ Yes ___ No RX Information _____
Is patient on blood thinners? ___ Yes ___ No RX Information _____
Is patient receiving home health care? ___ Yes ___ No Agency Name _____

PATIENT INSURANCE

Primary Insurance _____ ID# _____ Group# _____
Secondary Insurance _____ ID# _____ Group# _____

REFERRING PHYSICIAN

Physician Name _____ Practice Name/Location _____
Primary Phone _____ Fax _____ NPI _____
Who should we contact if we need additional information to process the request? _____