

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

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 _____
- _____

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

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? _____

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