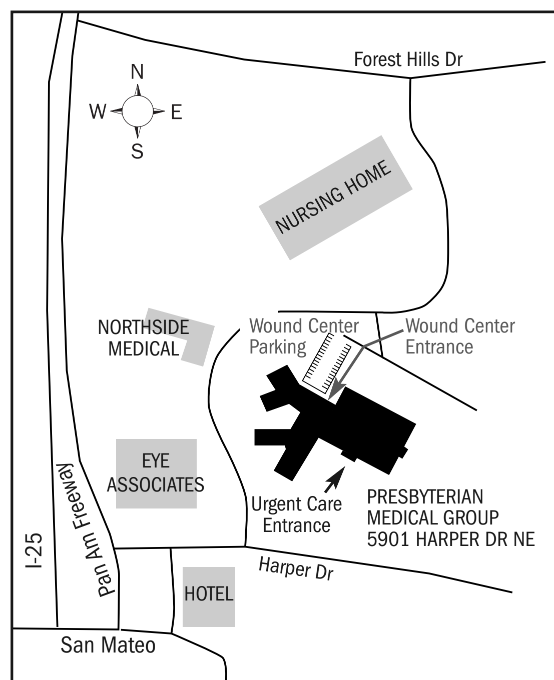
Presbyterian Wound Center and Hyperbaric Services

How to access the clinic:

1. Fill out the Presbyterian Wound Center Referral sheet or write a prescription with the patient's name, telephone number, date of birth, insurance, location from where the patient is being referred, the referring provider, telephone and fax number.
2. A provider order must be signed. The order should state: **Evaluate and treat wound, Ostomy management/education, or Hyperbaric Evaluation.** The order can be signed by any prescribing provider, i.e., MD, DPM, DO, CNS, NP, PA, CNM
3. A diagnosis must be given by the provider. This can be a medical diagnosis, condition, or symptom.
4. Call the Wound Center (823-8870) to notify us that a referral has been faxed. Give the location you are calling from, patient's name, and date of birth in case of fax failure.

Services Provided:

- Treatment for all types of wounds: diabetic, venous, arterial and pressure ulcers, second degree burns, post-trauma and surgical wounds
- Advanced therapies such as
  - **Hyperbaric Oxygen** (for wound and non-wound indications)
  - Vacuum Assisted Closure
  - Skin Substitutes
  - Wound care that speeds healing and decreases pain
- Board Certified Wound Specialists: interdisciplinary team
- Case Management for chronic wounds or complex cases
- Wound Prevention through education and long-term follow-up
- Ostomy Education and management, both pre- and post operative



Northside Presbyterian Facility
5901 Harper NE
Albuquerque, NM 87109
Telephone: (505) 823-8870
Fax: (505) 823-8875

Hours are by appointment only:
8 am - 4 pm Monday – Thursday
8 am - 12 pm Fridays
Closed holidays

phs.org

PRESBYTERIAN

Presbyterian Wound Center Order

Please complete the order form, have provider sign, then fax the information to the Wound Center.
The Wound Center will contact the patient to give instructions and appointment time.

Date: ____________________________

Referring Provider: __________________________________ Department: ______________________________

Office Address: ____

Provider Telephone: __________________________________ Fax: _________________________________

Patient Name: ____

Patient Telephone: ____

Alternate Contact (e.g., cell phone): ____

Patient DOB: ___________________ Insurance: ____

REQUIRED: Send medication list, H&P, lab or x-ray reports pertinent to diagnosis

Provider Order

Evaluate and treat:

- ❒ **Wound**
- ❒ **Ostomy**
- ❒ **Hyperbaric oxygen therapy**

Diagnosis:

Provider Signature: ____

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