Hyperbaric Oxygen Therapy Referral Form

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Patient Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ ZIP: _____

Phone: Primary _____ Secondary _____ Emergency _____

Insurance

Primary: _____ Secondary: _____

Hyperbaric Treatment Indication

- ☐ *Diabetic Foot Ulcer*
- ☐ *Necrotizing Soft Tissue Infections*
- ☐ *Carbon Monoxide Poisoning*
- ☐ *Gas Embolism*
- ☐ *Osteomyelitis*
- ☐ *Compromised/Preservation Flap & Grafts*
- ☐ *Other: _____*
- ☐ *Delayed Radiation Injuries (Soft Tissue or Bone Necrosis)*
- ☐ *Crush Injuries and suturing of severed limbs*
- ☐ *Acute Traumatic Peripheral Ischemia*
- ☐ *Gas Gangrene*
- ☐ *Arterial Insufficiencies (Central Retinal Occlusion & enhancement of healing select problem wounds)*

☐ Diabetic Foot Ulcer Criteria - must have all of the following:
- ☐ Patient has Type I ____ or Type II ____Diabetes and has a wound which is a result of diabetes
- ☐ Wagner Grade wound classification if applicable: _____
- ☐ Patient has failed an adequate course of standard wound therapy (no measurable signs of healing for 30 days)

Wound or problem location details: _____

Please send a copy of insurance cards, demographics, recent progress notes, recent H&P, wound measurements and any recent diagnostic studies if applicable. To expedite treatment, please provider copies of ECG, CXR and Labs completed within the last 30 days for review before the Hyperbaric Evaluation.

Diagnosis: _____

Primary Care MD: _____ Cardiologist or Specialist: _____

Referring Physician: _____ Signature: _____

Office Contact Person: _____ Phone: _____ Fax: _____

OFFICE USE ONLY:

- ☐ Referral not completed
- ☐ Insurance requires prior-authorization
- ☐ Clinic does not treat referring diagnosis
- ☐ Clinic is NOT Contracted with patient's assigned medical group
- ☐ Please redirect request to patient medical group.