Hyperbaric Oxygen Therapy Referral Form

DATE _____

PATIENT NAME: _____ DOB_____ SS#____-____-____

ADDRESS: _____PHONE (_____) _____-_____

_____EMAIL_____

This _____ y.o. Male/female is being referred to The Hyperbaric Department for Hyperbaric Oxygen Therapy (HBOT) as an adjunctive treatment for the diagnosis (or diagnoses) listed below.

DIAGNOSIS: (Check all diagnoses that apply)

- ☐ Diabetic with Chronic Ulcer of Lower Extremity (Wagner Grade III, IV, or V)
- ☐ Preservation/Preparation of compromised skin grafts/flaps
- ☐ Late Tissue Radiation Injury – i.e. osteoradionecrosis, hemorrhagic cystitis, etc.
- ☐ Chronic Refractory Osteomyelitis
- ☐ Other _____

To be eligible for HBOT, diabetic ulcers must have failed an adequate course of standard wound therapy of at least 30 days duration. All other diagnoses may begin treatment immediately.

Please attach a recent history & physical

(Any Medications, Allergies, and Past Medical History are useful for initial evaluation by our physicians):

Type of wound dressing: _____

What is the dressing change schedule? (Please circle) S M T W Th F S / Daily _____

TREATMENT PLAN:

The plan is to refer the patient for up to 30 hyperbaric oxygen treatments and, if evidence of wound healing (or radiation injury improvement) has been demonstrated, to continue therapy until the wound or injury has healed. There will be continued standard wound care during the hyperbaric oxygen treatment course per referring physician including surgical debridement if necessary. The patient will be encouraged to maintain good control of blood glucose levels and avoid nicotine and caffeine to maximize healing. In regards to osteoradionecrosis, we will follow treatment per Marx's Protocol (Stage I to Stage IIIR).

Additional Comments: _____

_____

_____

_____
Please Print Physician Name Only

_____
Physician or Physician Representative Signature

_____
UPIN

_____
NPI Number

_____
Street Address

_____
City/ Zip Code Zip Code

_____
Telephone Number Fax Number

Please return completed referral form along with your patient demographic sheet and recent H&P to:

Practice Manager
Euclid Hospital Hyperbaric Center
Fax: 216.692.7762
Phone: 216.692.7711

Please circle when serves you best for any brief correspondences with our Center Director: M T W TH F AM / PM

PRIMARY CARE PHYSICIAN: _____ PHONE: _____