Hyperbaric Oxygen Therapy Referral Form

Date: ______________

Patient Name: ____________________________ DOB: _______________ SS #: _______________

Address: ____

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Phone: (________) ____________-____________________

This __________ year old male / female is being referred for Hyperbaric Oxygen Therapy ("HBOT"), as an adjunct treatment for the diagnosis listed below:

Diagnosis: **(Check all that apply)**

________ Diabetic Ulcer of the Lower Extremity (Wagner Grade III, IV, V)

________ Chronic Refractory Osteomyelitis

________ Preservation/Preparation of Compromised Skin Graft/Flap

________ Late Radiation Injury (Radiation Cystitis, Osteoradionecrosis, Soft Tissue Radionecrosis)

________ Arterial Insufficiency with Ulceration

________ Other

Summary of Treatment Plan:
Initial treatment of 30 days of HBOT, as an adjunct to standard of care for above noted diagnosis, unless indicated otherwise. Each treatment is to be daily and 2-hours in duration. My objective is to treat the patient until the wound is fully healed. After 30 days, if evidence of healing has occurred, HBOT will be continued through healing. Continued HBOT will be coordinated with referring provider

Referring Provider Information:

_______________________________ X _______________________________

Referring Provider Name (printed) Referring Provider Signature Date/Time

____

NPI #

____

Street Address

____

City, State, Zip

____

Phone # Fax #

____

Primary Care Physician Name

Please fax completed for and supporting medical records to:

Hyperbaric Center at Euclid Hospital
Phone: 216-692-7711
Fax #: 216-692-7762