Hyperbaric Oxygen Therapy Referral Form

Date: _____

Patient Name: _____ DOB: _____ SS #: _____

Address: _____

_____

_____

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