HYPERBARIC OXYGEN THERAPY REFERRAL FORM

Date: _____

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ Phone #: _____

_____

_____

This _____ year old male/female is being referred for Hyperbaric Oxygen Therapy ("HBOT"), as an adjunctive treatment for the following diagnosis:

DIAGNOSIS: (Check all that apply or leave blank if unsure)

_____ Diabetic Ulcer (Wagner Grade III, IV, or V)

_____ Chronic Osteomyelitis

_____ Arterial Insufficiency with Ulceration

_____ Late Radiation Injury (Cystitis, Proctitis, Soft Tissue Radionecrosis, Osteoradionecrosis, etc.)

_____ Preservation of Failed or Threatened Surgical Flap/Graft

_____ Other: _____

Treatment Summary:

Initial treatment will be 30 days of HBOT, as adjunctive therapy to standard care for the above noted diagnosis, unless indicated otherwise. After 30 days of treatment, if evidence of healing has occurred, HBOT will be continued through complete healing. Continuation of HBOT will be coordinated with the referring provider.

Needed Supporting Medical Records: Please Attach the Patient's Most Recent Physical and/or Progress Notes, Demographics Sheet, and Insurance Information

Referring Provider Information:

_____

Referring Provider Name (printed) Referring Provider Signature Date

_____

NPI #

_____

Address City State Zip

_____

Phone # Fax #

Please Fax Completed Form & Supporting Medical Records to:

Mt. Juliet Center for Hyperbaric Medicine

Phone #: 615-754-7274

Fax #: 615-754-7275