Integrative Hyperbaric
Healing through Hyperbaric & Integrative Healthcare
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Loudoun Clinic Location Opening Winter 2022/23

Referral Form

Patient Name (First, Middle, Last):	Date of Birth (MM/DD/YYYY):
Patient Address:	Primary Phone:
Insurance Policy Type(s):	Insurance ID #(s):

Hyperbaric Oxygen Therapy Order: Check reason(s) for referral

□ Post-Radiation Injury after Cancer
□ Osteoradionecrosis/Soft Tissue Radionecrosis
□ Refractory Osteomyelitis
Imaging performed and confirmed ○ Yes ○ No ○ Unknown
If yes, please attach imaging report
Antibiotic Therapy ○ Yes ○ No ○ Unknown Area:
□ Ulcer: ○ Diabetic ○ Arterial ○ Venous ○ Mixed ○ Unknown
If Diabetic: A1C optimized ○ Yes ○ No ○ Unknown
Nutrition/Diet ○ Yes ○ No ○ Unknown
Antibiotic Therapy for at least 30 days ○ Yes ○ No ○ Unknown
Wagner Grade III+: ○ Yes ○ No ○ Unknown
□ Compromised/Non-Healing Wounds: ○ Graft ○ Flap ○ Crush Injury
For Ulcers & Wounds: Has Vascular been Optimized?
□ Thermal Burns ○ Yes ○ No ○ Unknown
□ Central Retinal Artery Occlusion
□ Severe Blood Loss Anemia
□ Idiopathic Sensorineural Hearing Loss
Date 1st noticed hearing loss_________ (please attach hearing test)
Corticosteroids used ○Yes ○ No ○ Unknown
If yes, dose ___________ and duration ___________
□ Other:

Medical History: (Check all that apply)

Suspected Disorders
□ Non-responsive to conventional medical/surgical management

Medical Conditions
□ Diabetes
□ Cancer
Type:
Radiation area(s):

□ Neuropathy
□ Peripheral Arterial Disease
□ Autoimmunity
□ Other:

Thank You for Your Referral!

Facility Name:	
Physician Name:	NPI:
Physician Address:	
Physician Phone:	Physician Fax:

DID YOU REMEMBER?

- **Please attach clinical notes and diagnostic results**
- **Fax or Email** this HBOT Referral Form to our contact above

Please attach a copy of patients ID and insurance card(s) front and back.
PHYSICIAN STATEMENT: I have carefully reviewed this form and find Hyperbaric Oxygen Therapy to be medically necessary.

REQUIRED* **Physician Signature:** ______________________ **Date:** __________