Integrative Hyperbaric
Healing through Hyperbaric & Integrative Healthcare
www.VirginiaHyperbaric.com

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Dr Rajesh Mehra, DO – Hyperbaric Medical Director

Referral Form

Patient Name:	**Date of Birth:**
Patient Address:	**Primary Phone:**
Insurance Policy Type(s):	**Insurance ID #(s):**

Medical Grade Hyperbaric Oxygen Therapy Order:

On Label/FDA Approved Indications Commonly Treated:

□ Post-Radiation Injury
□ Osteoradionecrosis/Soft Tissue Radionecrosis
□ Complications of Skin Graft/Flap: ○ Autograft ○ Allograft
□ Radiation Cystitis: ○ with Hematuria ○ without Hematuria
□ Refractory Osteomyelitis Confirmed w/ imaging: ○ Yes ○ No
□ Ulcer: ○ Diabetic Wagner Grade III+: ○ Yes ○ No ○ Vascular Optimized
□ Idiopathic Sensorineural Hearing Loss
□ Severe Blood Loss Anemia
□ Crush Injury □ Other:

Off Label Indications Commonly Treated:

□ Traumatic Brain Injury (TBI)/Stroke Recovery
□ Post-Surgical Compromised Wound Healing
□ Pre/Post-Operative/Plastic Surgery Healing
□ Adjunctive/Alternative Active Cancer Therapy
□ Chronic Pain/Inflammatory Diseases
□ Carbon Monoxide Poisoning (Sub-Acute)
□ Stem Cell Therapy Adjunct
□ Autism Spectrum Disorders
□ Dementia/Alzheimers
□ Post-Covid Syndrome
□ Chron's Disease/UC/IBD
□ PTSD/Mental Health
□ Lyme Disease
□ Sports Injuries
□ Anti-Aging □ Other:

Medical History & Prescription:

Suspected Disorders:

□ Non-responsive to conventional medical/surgical management

Medical Conditions:

□ Hypertension □ Asthma / COPD
□ Diabetes □ Thyroid Condition
□ Pneumothorax in past 6 months
□ Ear/Nose/Throat Condition(s)
□ Peripheral Arterial Disease
□ Autoimmunity
□ Epilepsy Medication(s):_____
□ Cancer Type(s):_____
Radiation area(s):_____
□ Medical Implant? Type(s):_____
□ Other:_____

HBOT Protocol:

Treatment Depth (1.5-2.4 ATA): _____
Treatment Time (60-150 mins): _____
Treatments Recommended (5-60): _____
Treatment Frequency (4-5x weekly)

Thank You for Your Referral!

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

PLEASE ATTACH & FAX:

REQUIRED FOR ON LABEL AUTHORIZATION:
Recent Clinicals including Diagnostics
We accept Medicare Standard and Supplementals, and most Cigna, Tricare and United policies.

PHYSICIAN STATEMENT: I have carefully reviewed this form and consider Hyperbaric Oxygen Therapy medically necessary for this patient.

REQUIRED* **Physician Signature:**_____ **Date:**_____