**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

### FDA Approved Indications:

- □ Post-Radiation Injury after Cancer
- □ Osteoradionecrosis/Soft Tissue Radionecrosis
- □ Refractory Osteomyelitis Confirmed w/ imaging: ○ Yes ○ No ○ Unknown
- □ Ulcer: ○ Diabetic ○ Arterial ○ Venous ○ Mixed ○ Unknown
  Wagner Grade III+: ○ Yes ○ No ○ Vascular Optimized
- □ Compromised/Non-Healing Wounds: ○ Graft ○ Flap
- □ Thermal Burns
- □ Central Retinal Artery Occlusion
- □ Severe Blood Loss Anemia
- □ Idiopathic Sensorineural Hearing Loss

### Other Common Indications:

- □ Traumatic Brain Injury (TBI)/Stroke Recovery
- □ 1.5ATA 30
- □ Post-Surgical Compromised Wound Healing
- □ Pre/Post-Operative Healing Optimization
- □ Adjunctive Alternative Cancer Therapy
- □ Chronic Pain/Inflammatory Diseases
- □ Dementia/Alzheimers
- □ Post-Covid Syndrome
- □ Anti-Aging
- □ Lyme Disease
- □ Sports Injuries
- □ Other

## Medical History & Prescription:

(Check all that apply and complete Treatment Rx)

### *Suspected Disorders:*

□ Non-responsive to conventional medical/surgical management

### *Medical Conditions:*

- □ Diabetes
- □ Cancer Type:_____
  Radiation area(s):_____
- □ Neuropathy
- □ Peripheral Arterial Disease
- □ Autoimmunity
- □ Other:_____

### *HBOT Prescription:*

**Treatment Depth (1.3-3.0 ATA): _____**
**Treatment Time (60-150 mins): _____**
**Treatments Recommended (5-80): _____**
**Treatment Frequency (3-5x weekly):**
**_____**

**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:**_____