HYPERBARIC® MEDICAL SOLUTIONS
Healing with every breath

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REFERRAL FOR HYPERBARIC OXYGEN THERAPY

Date: _____ **Patient Name:** _____ **Patient Phone #:** _____

Patient DOB:_____ **Insurance:** _____

Referring Provider Name: _____ **Phone Number:** _____ **Email:** _____

Please submit referral form with supporting demographic and clinical documentation via fax or email

Condition for which therapy is requested (check all that apply):

☐ Delayed Radiation Injury
Please note type of cancer and area of injury: _____

☐ Diabetic Lower Extremity Ulcers: Wagner grade III or IV (circle one)

Date of Diagnosis: _____ Length of time treated: _____

Vascular studies done? Y ☐ N ☐ If Yes - Date: _____

☐ Sudden Idiopathic Sensorineural hearing loss

Date of Onset: _____

☐ Preparation and/or preservation of compromised skin graft

☐ Failed Surgical Flap

☐ Chronic Osteomyelitis unresponsive to conventional medical/surgical management

Date of diagnosis: _____ Location: _____ Length of time treated: _____

☐ Crush Injury: acute vascular compromise (including surgical compromise)

☐ Health and Wellness

☐ Other: _____

Additional Comments:

_____

_____