



Southwest General

Partnering with  University Hospitals

Wound Care

Hyperbaric Oxygen Therapy Referral Form

Patient Label

Phone (440)816-5970 Fax (440)816-5975

Date: _____

Patient name: _____ DOB: _____

Patient address: _____ Phone: _____

Diagnosis and Requirements: Please check all that apply and document the needed requirements in the patient's progress note

Acute Peripheral Arterial Insufficiency with Diabetes

Documentation/date/type of vascular assessment/revascularization if applicable

Chronic Refractory Osteomyelitis

Confirmation of osteomyelitis via imaging study or pathology

Refractory to antibiotics (at least 6 weeks of IV antibiotic therapy)

Diabetic Ulcer of lower extremity

Wagner Grade III, IV or V

Evaluation and treatment of underlying PVD

30 days of wound care

Recent A1C

Pressure reduction/offloading

Topical wound treatment

Wound debridement

Wound is not infected or has been treated with antibiotics

Hemorrhagic Cystitis/Proctitis secondary to Soft Tissue Radio Necrosis

Documentation/ dates of radiation therapy

Cystoscopy/colonoscopy

Preservation of compromised skin grafts

Surgical/ note of failed/threatened graft/flap

Osteoradionecrosis

Documentation/ dates of radiation therapy

Documentation of overt fracture or bony resorption

Soft tissue radio necrosis/Late radiation injury

Documentation/ dates of radiation injury

OTHER _____

Referring Provider Signature _____ NPI# _____

Print name _____ Date/Time _____

Fax completed form and supporting medical records to: Hyperbaric Center at Southwest

Fax# (440) 816-5975



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