

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/threated graft/flap

_____ **Osteoradionecrosis**

_____ Documentation/ dates of radiation therapy

_____ Documentation of overt fracture or bony resportation

_____ **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

Phone (440)816-5970