

Patient Information:

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Primary Insurance: _____ Secondary Insurance: _____

Referring Physician Information:

Name: _____ Office Phone: _____

Specialty: _____ Office Fax: _____

Most Common Accepted:

- ☐ 1. Crush Injuries
- ☐ 2. Skin and Tissue Radionecrosis
- ☐ 3. Preparation and Preservation of Compromised Skin Grafts
(not primary management of wounds) (excludes artificial skin)
- ☐ 4. Chronic Refractory Osteomyelitis of _____
(unresponsive to conventional antibiotic and surgical management)
- ☐ 5. Acute Traumatic Peripheral Ischemia due to:
a. Iliac artery injury b. Axillary artery injury
c. Femoral artery injury d. Popliteal artery injury
- ☐ 6. Diabetic Wound of the Lower Extremities
(In patients who meet the following THREE criteria)
a. Patient has type I or II diabetes and has a lower extremity wound due to diabetes
b. Patient has a wound classified as Wagner grade III or higher
c. Patient has failed an adequate course of standard wound therapy
- ☐ 7. Osteoradionecrosis of _____
- ☐ 8. Necrotizing Fasciitis
- ☐ 9. Soft Tissue Radionecrosis of _____

S97

L59.8

T86.828

M86.6

S35.513 S75.0
S45.0 S85.0

TYPE I DIABETES E10.621
TYPE II DIABETES E11.621
TYPE I DIABETES E10.622
TYPE II DIABETES E11.622
(Non Pressure Ulcer of L97)

M27

M72.6

T66

Request for Diagnostic Information on Hyperbaric Oxygen (HBO) Therapy Candidates

Please provide the following diagnostic information with this referral if available; check box if included:

- | | |
|--|---|
| ☐ PA and LA chest x-rays (less than six months old) | ☐ EKG |
| ☐ Vascular or Doppler studies | ☐ Pulmonary function tests |
| ☐ Echocardiograms | ☐ Other |

Diagnosis: _____ ICD10 Code(s): _____

Brief Pt Hx: _____

Comments/Recommendation: _____

Physician Signature: _____ Date: _____

This form serves as a prescription for Hyperwell Oxygen Centers only.

