SOUTHERN OREGON hbOt 2

Southern Oregon HBOT
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HYPERBARIC OXYGEN THERAPY REFERRAL FORM

IMPORTANT! This form must be completed by the referring provider, who is licensed to prescribe HBOT, and submitted to Southern Oregon HBOT for prior authorization.

Patient name_____ DOB_____ Gender ❑M ❑F

Patient phone_____ Dx code(s)*(for which the pt is receiving HBOT)*_____

Insurance carrier_____ Policy #_____

My patient has been diagnosed with/being treated for: *please choose from the below options (those listed are covered by Medicare)*

- ❑ Actinomycosis
- ❑ Acute carbon monoxide poisoning
- ❑ Acute peripheral arterial insufficiency
- ❑ Acute traumatic peripheral ischemia
- ❑ Chronic refractory osteomyelitis
- ❑ Crush injuries and suturing of severed limbs
- ❑ Cyanide poisoning
- ❑ Decompression sickness
- ❑ Diabetic with chronic ulcer or lower extremity (Wagner Grade: III IV V)
- ❑ Gas embolism
- ❑ Gas gangrene
- ❑ Late tissue radiation injury - i.e. osteoradionecrosis, hemorrhagic cystitis, etc.
- ❑ Preservation/preparation of compromised skin graft/flaps
- ❑ Progressive necrotizing infection
- ❑ Other_____

I am prescribing the following HBOT as an adjunctive treatment for the above patient: *please complete all bolded sections below*

Typical protocol is 30-40 sessions within 8 weeks at 2.0 ATA, for duration of 90 min, with no air-break, 3-5 days per week(Mon-Fri)

# of sessions:

- ❑ 10 sessions, then follow up with prescribing provider
- ❑ 20 sessions, then follow up with prescribing provider
- ❑ 40 sessions, then follow up with prescribing provider
- ❑ Other:_____

Pressure/Depth

- ❑ 2.0 ATA(14.7 psi)
- ❑ 2.5 ATA(22.0 psi)
- ❑ 3.0 ATA(29.4 psi)
- ❑ Other_____

Duration

Breathing 100% O_2 for _____minutes

Frequency:_____/day_____/week

Air break: ____*(5-10)*min air-break Q ____min at pressure. ❑None

Medications to take prior to session:_____

The following exams were performed to determine patients eligibility to undergo HBOT: *refer to the provided laminated Additional Information form regarding the following*

❑ Eye exam ❑ Ear exam (TEED scale___) ❑ Neurology exam ❑ Respiratory exam

Patient educated on risks of: *patient must be educated on each of the following*

❑ Pneumothorax ❑ Blood glucose ❑ Vision changes ❑ Oxygen toxicity ❑ Eardrum rupture

By signing below, I *(prescribing provider)* declare that the above patient is eligible and fit to receive HBOT, and there are no contraindications. *refer to the laminated Additional Information form for a list of contraindications (the list should not be assumed to include all contraindications for HBOT)*

Provider name_____ NPI_____ Provider phone_____

Provider signature_____ Date signed_____

Provider address_____

Important: *Please make sure the form is completed in its entirety. Incompletion will result in the form being returned, and delay the patients ability to start HBOT therapy*