

Hyperbaric Oxygen Therapy

Fax: 504.903.5081

Patient Label/Stamp

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ____/____/____

Date of Birth: ____/____/____ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email: _____

Please Indicate Reason for Referral :

- | | |
|---|---|
| <input type="checkbox"/> 039.9 Actinomycosis | <input type="checkbox"/> 993.3 Decompression Illness |
| <input type="checkbox"/> 986 Acute Carbon Monoxide Poisoning | <input type="checkbox"/> 250.8 Diabetic Foot Wounds (+ 707.10) |
| <input type="checkbox"/> 444.9 Acute Peripheral Arterial Insufficiency | <input type="checkbox"/> 250.8 Diabetic Wound of the Lower Extremity (+707.10) |
| <input type="checkbox"/> 904.9 Acute Traumatic Peripheral Ischemia: Lower Extremity | <input type="checkbox"/> 958.0 Gas Embolism |
| <input type="checkbox"/> 903.9 Acute Traumatic Peripheral Ischemia: Upper Extremity | <input type="checkbox"/> 040.0 Gas Gangrene |
| <input type="checkbox"/> 440.23 Arterial Insufficiency Wounds | <input type="checkbox"/> 526.89 Osteoradionecrosis/Soft Tissue Radionecrosis |
| <input type="checkbox"/> 362.31 Central Retinal Artery Occlusion | <input type="checkbox"/> 728.86 Necrotizing Fasciitis |
| <input type="checkbox"/> 707 Chronic Non-Healing Wound | <input type="checkbox"/> 996.52 Preparation/Preservation of Compromised Skin Grafts |
| <input type="checkbox"/> 730.10 Chronic Refractory Osteomyelitis | <input type="checkbox"/> 686.09 Pyoderma gangrenosum: (Meleny's Ulcer) |
| <input type="checkbox"/> 987.7 Cyanide Poisoning ; 989.0 | <input type="checkbox"/> 949.0 Thermal Burn |
| <input type="checkbox"/> 927.9 Crush Injuries/Suturing of Severed Limbs Lower Extremity | <input type="checkbox"/> Other ICD: _____ Diagnosis: _____ |
| <input type="checkbox"/> 928.9 Crush Injuries/Suturing of Severed Limbs Upper Extremity | |

____ CHECK HERE TO REQUEST A PHONE CALL TO DISCUSS THE CASE YOU WISH TO REFER.

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ____/____/____ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 02/19/09