OxygenWell

Hyperbaric & Regenerative
Medicine Center

Oxygenwell.com
(818) 661-0939
Sherman Oaks and Calabassas

Hyperbaric Oxygen Therapy Referral Form

Patient Information

Full Name: _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male

Insurance Provider: _____ Insurance ID#: _____

E-mail: _____ Phone: _____

Referral Information

Referring Provider's Name: _____

Specialty: _____ Practice/Clinic Name: _____

Phone: _____ Fax: _____ E-mail: _____

Medical Information

Diagnosis/Condition:

- ☐ Soft Tissue Radiation Necrosis*
- ☐ Radiation Cystitis*
- ☐ Radiation Proctitis (*not Medicare)*
- ☐ Osteo Radiation Necrosis (*not Medicare)*
- ☐ Pre and Post Dental Extractions for a Radiated of Mandible*
- ☐ Chronic Osteomyelitis*
- ☐ Compromised Skin Graft/Flap**
- ☐ Diabetic Foot Ulcer***
- ☐ Crush Injury and Compartment Syndrome****
- ☐ Sudden Sensorineural Hearing Loss (*not Medicare)**
- ☐ Avascular Necrosis (Osteonecrosis) * only Cigna and United Healthcare cover*

Follow standard of care medical protocol for:
90 minutes at pressure, approximately 125 minutes in the chamber
or _____

*40-60 sessions
**20 sessions
*** 30 sessions
**** up to 10 sessions
Or _____

Referring Provider's Signature _____