OxygenWell
HYPERBARIC & REGENERATIVE MEDICINE CENTER

Sherman Oaks: 15301 Ventura Blvd., Suite P-12, Sherman Oaks, CA 91403
Calabasas: 23500 Park Sorrento, Suite A2, Calabasas, CA 91302
Phone (818) 661-0939 · oxygenwell.com

Hyperbaric Oxygen Therapy Referral Form

Date of referral _____

Priority: ☐ Routine ☐ Urgent / time-sensitive (graft/flap, SSNHL, acute ischemia) Location: ☐ Sherman Oaks ☐ Calabasas

1. PATIENT INFORMATION

Full name _____ Date of birth (MM/DD/YYYY) _____ Sex ☐ F ☐ M ☐ Other

Phone _____ Email _____ Preferred language _____

Primary insurance _____ Member ID _____ Secondary insurance (if any) _____

2. REFERRING PROVIDER

Provider name & credentials _____ Specialty _____ NPI _____

Practice / clinic _____ Phone _____ Fax _____ Email _____

3. DIAGNOSIS & INDICATION (CHECK ALL THAT APPLY)

INDICATION	TYPICAL COURSE	INDICATION	TYPICAL COURSE
☐ Soft tissue radionecrosis	40–60 sessions	☐ Compromised skin graft or flap	20 sessions
☐ Radiation cystitis	40–60 sessions	☐ Diabetic foot ulcer — Wagner grade: ____	30 sessions
☐ Radiation proctitis	40–60 sessions	☐ Crush injury / compartment syndrome	up to 10 sessions
☐ Osteoradionecrosis	40–60 sessions	☐ Sudden sensorineural hearing loss*	20 sessions
☐ Pre/post dental extraction in irradiated mandible	40–60 sessions	☐ Avascular necrosis (osteonecrosis)**	40–60 sessions
☐ Chronic refractory osteomyelitis	40–60 sessions	☐ Other: _____	

ICD-10 code(s) _____ Brief clinical summary (onset, prior treatment, current status) _____

** Not a Medicare-covered indication; many PPO plans cover it. Best results when started within 2 weeks of onset.*
*** Covered by some commercial plans (e.g., Cigna, UnitedHealthcare); not covered by Medicare.*
Typical courses are estimates; the final number of sessions depends on clinical response and insurance authorization.

4. TREATMENT ORDER

☐ Treat per standard protocol: 90 minutes at pressure (about 125 minutes in the chamber), once daily, 5 days per week

☐ Other protocol / number of sessions: _____

Relevant history & precautions (e.g., pneumothorax, seizure disorder, COPD, claustrophobia, chemotherapy, implanted devices)

5. PLEASE SEND WITH THIS REFERRAL

☐ Recent H&P or progress note ☐ Medication & allergy list ☐ Insurance card (front & back) ☐ Imaging / pathology reports
☐ Radiation treatment summary ☐ Wound measurements & photos ☐ Audiogram (hearing loss) ☐ Surgical / operative note

Referring provider signature _____ Printed name _____ Date _____

Return by fax to (619) 273-0919 or secure email: info@oxygenwell.com · beth@oxygenwell.com · isaac@flyercorp.com

Fill in on screen, save the PDF, then attach it to your email. Our team verifies benefits, obtains prior authorization and schedules your patient.

Confidential: contains protected health information. Send by secure fax or secure email only. Questions: (818) 661-0939.