



NORTHERN NEVADA HYPERBARICS

Hyperbaric Oxygen Therapy Referral Form

Center for Advanced Medicine B, 1500 E. Second St., 104, Reno, NV 89502

Phone # (775) 826-2084 Fax # (775) 826-2087 Cell # (775) 815-1588

Patients Name: _____ Date of Birth: _____

Date of Referral: _____ Insurance Primary/Secondary: _____

Hyperbaric Oxygen Therapy Evaluate and Treat

Referring Provider (Print): _____

Provider Signature: _____

Providers Office Contact Name: _____

Providers Phone Number: _____

Covered Conditions

- Soft Tissue Radionecrosis – Adjunct Therapy (Late Effects of Radiation)
- Radiation Induced Cystitis/Proctitis
- Osteoradionecrosis
- Chronic Refractory Osteomyelitis – Unresponsive to conventional medical and surgical treatment
- Gas Gangrene
- Decompression Sickness
- Crush Injuries
- Necrotizing Fasciitis
- Compromised Skin Grafts
- Acute Peripheral Arterial Insufficiency
- Diabetic Non Healing Wound*

*Diabetic Lower Extremity Non-Healing Wound:

Wound Type/Location/Wagner Grade III: _____

Wound Care for How Long (Patients have to have failed 30 days): _____

Bone Infection Y/N

Bone Scan Y/N

Exposed Bone Y/N

* Please Provide Wound Care Notes, MRI's, Bone Scans, and CT Scans

Please Fax the Following to 775-826-2087 Please Include Insurance Information, Face Sheet, H&P, Office Notes, Chest X-ray, Lab Work, Oncologist Note, Radiation Note, and Wound Care Notes