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HYPERBARIC OXYGEN THERAPY PATIENT REFERRAL REQUEST

Please call or email for questions
www.cypresshbot.com email:info@cypresshbot.com

Fill out the following information to facilitate patient treatment and billing requirements:

Date: _____ Referring Physician: _____ Phone: _____

Email: _____ I am referring a patient for ☐ HBO Therapy (G0277 / C1300)

Patient Name: _____ Phone: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Member No. _____ Insurance _____

Diagnosis: _____

Codes (if known) : _____

Please include a copy of the patient's Chart Notes, including:

- Date of first diagnosis, any adjunctive therapies or treatments
- H&P, medical summary

Please indicate if any of these issues may be relevant for this patient

- ☐ Post surgery, post graft, post flap or post debridement
- ☐ Slow healing wound or the presence of osteomyelitis
- ☐ Presence of co-morbidity (Diabetes,PVD,RI,CAD,other)
- ☐ Presence of gangrene/necrosis
- ☐ Prevent amputation or grafting or further grafting
- ☐ Osteoradionecrosis (ORN)
- ☐ Other _____

Physician's Signature

Phone No. / Fax No.

Date