



**SANTA YNEZ VALLEY  
HYPERBARIC CENTER**

MRN  
Patient Name

(Patient Label)

**PATIENT REFERRAL FORM - Hyperbaric Medicine**

If your evaluation shows that the patient could benefit from HBO Therapy, please complete the form below and send via fax (805) 693-8107.

| REASON FOR REFERRAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <input type="checkbox"/> Actinomycosis (Cutaneous) (A42.89)<br><input type="checkbox"/> Actinomycosis (Unspec. Site) (A42.9)<br><input type="checkbox"/> Acute Carbon Monoxide Poisoning (T58.8XA – T58.94XA)<br><input type="checkbox"/> Acute Peripheral Arterial Insufficiency (I77.1)<br><input type="checkbox"/> Acute Traumatic Peripheral Ischemia (I73.9)<br><input type="checkbox"/> Acute Traumatic Peripheral Ischemia (Upper Leg) (S75.009A)<br><input type="checkbox"/> Acute Traumatic Peripheral Ischemia (Lower Leg) (S85.009A)<br><input type="checkbox"/> Central Venous Retinal Occlusion (H34.10 -H34.819)<br><input type="checkbox"/> Crushing Injury (S47.1XXA – S97.122A)<br><input type="checkbox"/> Cyanide Poisoning (T65.0X1A-T65.0X4S)<br><input type="checkbox"/> Decompression Illness (T30.3XXA-T3XXS)<br><input type="checkbox"/> Diabetes/Diabetic<br><input type="checkbox"/> Diabetes Mellitus due to Underlying Conditions (E08- E08.9)<br><input type="checkbox"/> Type 1 – Diabetes Mellitus – (E10 – E10.9)<br><input type="checkbox"/> Type 2 – Diabetes mellitus – (E11 – E11.9)<br><input type="checkbox"/> Other spec. diabetes mellitus – (E13- E13.9) | <input type="checkbox"/> Embolism and Thrombosis of Arteries (upper/lower extremities, iliac artery)<br>Acute Peripheral Arterial Insufficiency (Lower Extremity) (I74.2-I74.9)<br><input type="checkbox"/> Gas Gangrene (A48.0)<br><input type="checkbox"/> Gas Embolism (T79.0XXA)<br><input type="checkbox"/> Gas Embolism Inj / Infusion (T80.0XXA)<br><input type="checkbox"/> Hemorrhagic Cystitis (N30.90)<br><input type="checkbox"/> Hip & Thigh Crush Inj. (S77.11XA/S77.12XA)<br><input type="checkbox"/> Ischemic Optic Neuropathy (H47.09)<br><input type="checkbox"/> Inflammatory Conditions of Jaws (M27.2)<br><input type="checkbox"/> Late Effects of Crush Injuries (T87.0X9/T87.1X9)<br><input type="checkbox"/> Local Infection of Skin & Subcutaneous Tissue (L08.9)<br><input type="checkbox"/> Osteomyelitis<br><input type="checkbox"/> Chronic (M86.30-M86.69)<br><input type="checkbox"/> Other (M86.8X0—M86.8X9)<br><input type="checkbox"/> Unspecified (M86.9)<br><input type="checkbox"/> Other/Unspec. Effects of High Alt (T70.20XA/T70.29XA) | <input type="checkbox"/> Progressive Necrotizing Fasciitis (M72.6)<br><input type="checkbox"/> Prep/Preser of Compromised Skin Grafts (T86.820-T86.829)<br><input type="checkbox"/> Pyoderma Gangrenosum (L88)<br><input type="checkbox"/> Radiation Proctitis (K52.0)<br><input type="checkbox"/> Radiation Cystitis (N30.40-N30.41)<br><input type="checkbox"/> Sensorineural Hearing Loss (H90.3/H90.41-H90.42/H90.5)<br><input type="checkbox"/> Skin Ulcer (L98.499)<br><input type="checkbox"/> Soft Tissue Radionecrosis (L59.8-L59.9)<br><input type="checkbox"/> Soft Tissue Disorder, Unspecified (M79.9)<br><input type="checkbox"/> Ulcer of Lower Limb<br><input type="checkbox"/> Lower Limb Unspec. (L97.911-L97.924)<br><input type="checkbox"/> Other Part of Lower Limb (I70.231- 170.9)<br><input type="checkbox"/> Unspecified Open Wound (S81.009A/S81.809A/S91.009A)<br><br><input type="checkbox"/> Unlisted<br>(Please Specify with ICD10 Code)<br><br><b>Other services:</b><br><input type="checkbox"/> TCPO2 (93923/93923)<br><input type="checkbox"/> Dive Physical (Z00.8) |

| PATIENT INFORMATION |                                                                           |             |                       |
|---------------------|---------------------------------------------------------------------------|-------------|-----------------------|
| <b>Name:</b>        | <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female | <b>SSN:</b> | <b>Date of Birth:</b> |

|                                                 |                    |                    |                |
|-------------------------------------------------|--------------------|--------------------|----------------|
| <b>Address (Street, City, State, Zip Code):</b> |                    |                    |                |
| <b>Home Phone:</b>                              | <b>Work Phone:</b> | <b>Cell Phone:</b> | <b>E-mail:</b> |

| INSURANCE INFORMATION  |                       |                      |                        |
|------------------------|-----------------------|----------------------|------------------------|
| <b>Insurance Name:</b> | <b>Policy Number:</b> | <b>Group Number:</b> | <b>Effective Date:</b> |

| CLINICAL INFORMATION                               |               |             |                |
|----------------------------------------------------|---------------|-------------|----------------|
| <b>Clinical history relevant to this referral:</b> |               |             |                |
| <b>Past Medical History:</b>                       |               |             |                |
| <b>Desired Goals:</b>                              |               |             |                |
| <b>Referring Physician:</b>                        | <b>Phone:</b> | <b>Fax:</b> | <b>E-mail:</b> |