Scottsdale
HYPERBARIC CENTER®

Patient Referral Form for Hyperbaric Oxygen Therapy (HBOT)

to be submitted by the referring physician – HCPCS G0277

PATIENT INFORMATION

Date: _____
Patient Name: _____
Patient Phone: (_____) _____-_____
Patient Date of Birth: _____ /_____ /_____

DIAGNOSIS(ES) and ICD-10 CODES ARE REQUIRED:

☐ Diabetic Non-Healing Wound	ICD-10 code:_____
☐ Soft Tissue radionecrosis	ICD-10 code:_____
☐ Osteoradionecrosis	ICD-10 code:_____
☐ Chronic refractory osteomyelitis	ICD-10 code:_____
☐ Progressive necrotizing infections	ICD-10 code:_____
☐ Sudden or acoustic hearing loss or deafness	ICD-10 code:_____
☐ Delayed Radiation Injury	ICD-10 code:_____
☐ Preparation and/or preservation of compromised Skin Graft	ICD-10 code:_____
☐ Failed Surgical Flap	ICD-10 code:_____
☐ Crush Injury	ICD-10 code:_____
☐ Other:_____	ICD-10 code:_____

PATIENT CLEARED FOR HYPERBARIC OXYGEN THERAPY BY PROVIDER:

- ✓ **Patients' ears are clear**
- ✓ **Patients' chest is clear**
- ✓ **Patient does not have a Pneumothorax or known lung issue**
- ✓ **Patient does not have a known contraindication for HBOT**

Patient is APPROVED for HBOT per protocol. *Opt note*_____
or
Patient is APPROVED for HBOT with the referring providers protocol as follows:

ATA :_____ PSI:_____
Minutes in HBOT chamber: 90mins or 60mins
# of treatments: _____ Days per week: 5 or _____

I have discussed the benefits and risks of Hyperbaric Oxygen Therapy (HBOT) with my patient.

REFERRING PHYSICIAN'S SIGNATURE: Required_____

Referring Providers name:_____

Phone:_____ Fax: _____

Email:_____ NPI: _____

Email or Fax this Patient Referral Form and medical chart notes to:

Scottsdale Hyperbaric Center | 9923 E Bell Rd. #120, Scottsdale, AZ 85260
Fax: 480-590-6145 | info@scottsdalehyperbaric.com | NPI# 1013772078