Scottsdale HYPERBARIC CENTER®

Patient Referral Form for Hyperbaric Oxygen Therapy (HBOT)

PATIENT INFORMATION

Date: _____

Patient Name: _____

Patient Phone: (_____) _____-_____

Patient Date of Birth: _____/_____/_____

Diagnosis / Indication	ICD-10 Code(s)	Protocol (# of Sessions)
☐ Diabetic non-healing foot ulcers	ICD-10 code: E11.621	Up to 30 sessions (30 Days)
☐ Soft tissue radionecrosis	ICD-10 code: L59.8	40 - 60 sessions
☐ Osteoradionecrosis (ORN) of the jaw	ICD-10 code: M27.2	40 sessions
☐ Prophylactic treatment (pre- and post-dental surgery in previously irradiated jaw) ***	ICD-10 code: M27.2	30 sessions
☐ Chronic refractory osteomyelitis	ICD-10 code: M86.68	20 - 60 sessions
☐ Idiopathic sudden sensorineural hearing loss***	ICD-10 code: H91.21(R) H91.22 (L)	10 - 20 sessions
☐ Radiation cystitis	ICD-10 code: N30.40	40 - 50 sessions
☐ Radiation proctitis***	ICD-10 code: K62.7	40 - 50 sessions
☐ Compromised skin graft or flap (preparation and/or preservation)	ICD-10 code: T86.821	10 - 20 sessions
☐ Avascular Necrosis	ICD-10 code: M87.0	30 - 40 sessions
☐ Other:_____	ICD-10 code:	

***** NOT covered by Medicare**

Patient CLEARED for HBOT by the referring 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**

The patient is APPROVED for HBOT with the protocol as follows:

- **Treatment Pressure:** 2.0 ATA – 2.4 ATA (atmospheres absolute)
- **Time at Pressure:** 90 minutes at ATA
  (Total chamber time may exceed 120 minutes including compression/decompression/airbrakes)
- **Frequency:** 5 sessions per week (Monday–Friday)
- **Total Sessions:** Per protocol/medical necessity
- 100% medical-grade oxygen

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

Referring PROVIDER SIGNATURE: Required_____

Referring Providers name:_____

Phone:_____Fax: _____ Facility:_____

Email:_____NPI: _____

Please fax the following to 480-590-6145: Insurance information, face sheet, H&P, office notes, chest X-ray, lab work, oncologist note, radiation note, cystoscopy, audiometry, and wound care notes.

Scottsdale Hyperbaric Center | 9923 E Bell Rd. #120, Scottsdale, AZ 85260
Fax: 480-590-6145 | info@scottsdalehyperbaric.com | Office: 480-590-5277 | NPI# 1013772078

Scottsdale HYPERBARIC CENTER®

Prescription for Hyperbaric Oxygen Therapy (HBOT)

PATIENT INFORMATION

Date: _____

Patient Name: _____

Patient Phone: (_____) _____-_____

Patient Date of Birth: _____/_____/_____

Diagnosis / Indication	Protocol (# of Sessions)
☐ TBI/Concussion	40 – 80 sessions
☐ Stroke Recovery	40 - 80 sessions
☐ Cosmetic Surgery Recovery (Pre/Post)	10 - 20 sessions
☐ Hair Transplant	5 - 10 sessions
☐ Headache or Migraine	As needed
☐ Auto-Immune Disease	40 sessions
☐ Alzheimer's/Dementia	40 - 80 sessions
☐ Stem-Cells	10 - 12 sessions
☐ Tinnitus	20 sessions
☐ Anti-Aging Health	60 sessions in 90 days
☐ Other:_____	

Patient CLEARED for HBOT by the referring 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**

Hyperbaric Oxygen Therapy per center protocol.

- **ATA (atmospheres absolute): 1.5-2.4**
- **Minutes: 60 -90 minutes**
- **100% Medical Grade Oxygen**

Hyperbaric Oxygen Therapy (HBOT) for this diagnosis is considered *off-label* by the FDA and CMS. Clinical evidence exists, but treatment is not FDA-cleared for this indication. Patients have been informed of risks, benefits, and investigational nature of therapy.

PROVIDER SIGNATURE: Required_____

Providers name:_____

Phone:_____Fax: _____ Facility:_____

Email:_____NPI: _____

Please fax the patient's referral with recent H&P notes to 480-590-6145. Additional records may be requested if needed for safety clearance.

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