



Utah Hyperbaric Center



209 E Gordon Ave, Ste 1 & 2

Layton, UT 84041

385-786-6100 – Main

385-786-6102 - Fax

## ORDER TO EVALUATE & TREAT HYPERBARIC OXYGEN THERAPY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: F  M

Social Security #: \_\_\_\_\_ Veteran: Yes  No

Patient Address: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

Next of Kin/CAREGIVER: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ DNR: Y  N

Medicare/Medicaid #: \_\_\_\_\_ Private Ins: \_\_\_\_\_

Name & Phone # of Primary Contact Person: \_\_\_\_\_

Physician Office Contact Name: \_\_\_\_\_

Physician Office Contact Phone #: \_\_\_\_\_

### COVERED CONDITION ACCORDING TO MEDICARE/MEDICAID (CMS) please check all that apply

- Actinomycosis
- Acute Traumatic Peripheral Ischemia
  - Soft Tissue Radionecrosis - Adjunct Therapy (Late Effects of Radiation)
- Radiation Induced Cystitis/Proctitis
- Pre & Post Treatment surgery
  - Radiated jaw
  - Other \_\_\_\_\_
- Osteoradionecrosis
- Chronic Refractory Osteomyelitis – unresponsive to conventional treatment
- Gas Gangrene
- Decompression Sickness
- Crush Injuries & suturing of severed limbs
- Necrotizing Fasciitis
- Compromised Skin Graft
- Acute Peripheral Arterial Insufficiency
- Diabetic non-healing wound
  - Please explain on next page

**Diabetic Non-Healing Wound:**

Wound type: \_\_\_\_\_

Location: \_\_\_\_\_

Wagner Grade: \_\_\_\_\_ (Wagner grade III or higher)

Wound care length: \_\_\_\_\_ (documented 30 days of failed treatment)

**Bone Infection:** Yes  No  **Bone Scan:** Yes  No  **Exposed Bone:** Yes  No

Other important information:

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Printed Name:** \_\_\_\_\_

**Please fax this form and supporting documentation including Insurance information, Face Sheet, H&P, Office notes, X-rays (if applicable), Lab work, etc.**