

HYOX MEDICAL TREATMENT CENTER REFERRAL FOR TREATMENT

HYPERBARIC OXYGEN THERAPY • PHYSICAL THERAPY • RESPIRATORY THERAPY • SOCIAL SERVICES

PATIENT INFORMATION

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F SSN: _____ DOB: _____

WE PRE-CERTIFY MOST INSURANCE PLANS WITH THE FOLLOWING INFORMATION:
Please fax a copy of the insurance card (front and back) with your referral form.

Insurance: _____ Aetna	_____ Coventry/SouthCare	_____ State Health	Type: _____ Auto	_____ PPO
_____ Blue Cross Blue Shield	_____ Humana	_____ United Healthcare	_____ HMO	_____ POS
_____ Cigna	_____ Medicare	_____ Other: _____	_____ Indemnity	_____ WC

Policy Number: _____ Group Number: _____

Referring Physician: _____ Specialty: _____

Phone: _____ Fax: _____

CLINICAL INFORMATION

Current Medical Findings: _____

Past Medical History: _____

Desired Goals: _____

Contraindications: ___ None ___ Other: _____

Allergies: ___ PCN ___ ASA ___ Codeine ___ Other: _____

Referring Physician Signature: _____ Date: _____

<p>HYPERBARIC OXYGEN THERAPY</p> <p>___ Carbon Monoxide Poisoning</p> <p>___ Crush Injury/Compartment Syndrome</p> <p>___ Decompression Illness</p> <p>___ Diabetic Wound</p> <p>___ Failure of Flap/Skin Graft</p> <p>___ Gas Gangrene</p> <p>___ Hypoxic Wound, Chronic</p> <p>___ Ischemias</p> <p>___ Necrotizing Soft Tissue Infections</p> <p style="padding-left: 20px;">___ Staph</p> <p style="padding-left: 20px;">___ MRSA</p> <p style="padding-left: 20px;">___ Pseudomonas</p> <p>___ Osteomyelitis, Chronic</p> <p>___ Osteoradionecrosis</p> <p>___ Soft Tissue Radionecrosis</p> <p>___ Other Diagnosis: _____</p>	<p>PHYSICAL THERAPY</p> <p>___ Abnormality of Gait</p> <p>___ Adhesive Capsulitis</p> <p>___ Amputation _____</p> <p>___ Anodyne</p> <p>___ Carpel Tunnel Syndrome</p> <p>___ Difficulty Walking</p> <p>___ Displacement of Disc</p> <p>___ Dysfunction, Lumbar</p> <p style="text-align: center;">RESPIRATORY THERAPY</p> <p>___ Asthma</p> <p>___ COPD</p> <p>___ Pneumonia</p> <p>___ Shortness of Breath</p> <p>___ Trancutaneous Oxygen Measurement</p>	<p>___ Dysfunction, Sacroiliac</p> <p>___ Foot Drop</p> <p>___ Fracture _____</p> <p>___ Injury _____</p> <p>___ Pain _____</p> <p>___ Rupture, Achilles Tendon</p> <p>___ Weakness, Muscle</p> <p style="text-align: center;">SOCIAL SERVICES</p> <p>___ Adjustment to Impairment</p>
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REFERRAL FOR TREATMENT

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Dear Physician:

Thank you for your referral of this patient. Due to government regulations, this patient will not be seen until this form is returned to us. You may fax the referral for treatment form to us along with any physician notes to 678.303.3205. Please note: Faxing is not a substitute for mailing. Thank you.

Please send the original referral form with the patient or mail to: HyOx Medical Treatment Center
2550 Windy Hill Road, Suite 110
Marietta, GA 30067

Email: info@hyox.com
Website: www.hyox.com

Dear Patient:

Your appointment has been scheduled with _____ on: M T W TH F
_____ at _____ AM or PM
(Date) (Time)

The following is a list of things to remember to bring with you on your first visit at HyOx Medical Treatment Center:

- ✓ Photo I.D.
- ✓ Insurance Card (s)
- ✓ List of Current Medications
- ✓ List of Doctors

DIRECTIONS TO HYOX

From I-75, exit at Windy Hill Road (exit 260). Go west approximately 1/5 mile and turn left at the second traffic light (the entrance to Wellstar Windy Hill Hospital).

HyOx is located on the ground floor of The Pavilion at Windy Hill (the building on your left with the canopy over the front entrance).

2550 Windy Hill Road • Suite 110
Marietta, Georgia 30067

678.303.3200
678.303.3205 FAX

