



901 Campus Dr. Suite 206B, Daly City, CA 94015
Phone: 650-356-8800 Fax: 650-376-5511

Hyperbaric Medicine Consultation Referral

DATE _____

PATIENT NAME _____
LAST FIRST

PATIENT PHONE # _____ PATIENT DOB _____

PATIENT EMAIL _____

Diagnosis ICD-10 code/ Reason for Consultation/Referral: _____

Has patient had radiation treatment? CIRCLE YES NO If YES provide details:

Does patient have diabetes? CIRCLE YES NO

Comments:

REFERRING PROVIDER _____ SIGNATURE _____

PHONE # _____ FAX # _____

EMAIL _____

****Please include chart notes and any other documents pertaining to reason for consult.****