



Post Procedure Evaluation

Date: \_\_\_\_\_

Patient Name. \_\_\_\_\_

LAST

FIRST

Referring Provider:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Patient is status post (provide date of procedure/event)

- Abdominoplasty
- Body Contouring/Fat grafting
- Face Lift
- Hair Transplant
- Idiopathic sudden sensorineural hearing loss
- Long Covid
- Mastectomy
- Mental health concerns
- Osteonecrosis
- Radiation tissue damage
- Rhinoplasty
- Stroke/TBI

Other: \_\_\_\_\_

I am concerned that the patient has the following tissue:

- Bone flap/graft
- Skin graft
- Soft tissue flap/graft

Other: \_\_\_\_\_

That is

- Ischemic
- Compromised
- Threatened
- Failing

Other: \_\_\_\_\_

Additional Comments:

I am referring this patient for hyperbaric oxygen therapy evaluation and treatment.

\_\_\_\_\_  
Referring Provider Signature