

LYMPHATIC TREATMENT REFERRAL FORM

NORTH GEORGIA CENTER FOR HYPERBARIC MEDICINE & WOUND CARE

1505 Northside Boulevard, Suite 1300, Cumming, GA 30041 | P: 678-388-9511 | F: 678-388-9544

(Patient Name)		(Date of Birth)	
(Address)	(City)	(State)	(Zip)
(Primary Phone)		(Secondary Phone)	
(Primary Insurance Carrier)	(Primary Insurance ID #)	(Secondary Insurance Carrier)	(Secondary Insurance ID #)
(Referring Physician)		(Physician Phone)	(Physician Fax)

PLEASE FAX COPIES OF PATIENTS INSURANCE CARDS AND MEDICAL RECORDS WITH THIS FORM

LYMPHATIC DIAGNOSIS:

- Post Mastectomy Lymphedema Syndrome
- Lymphedema Post Surgical
- Lymphedema
- Other: _____

INVOLVED AREAS:

- Upper Extremity Left Right
- Lower Extremity Left Right
- Other: _____

OTHER DIAGNOSIS:

- Diabetic Wound
- Failure of Skin Graft/Flap
- Osteoradionecrosis
- Cystitis
- Radiation Tissue Damage/Soft Tissue Radionecrosis
- Osteomyelitis, Chronic
- Proctitis
- Other: _____

PHYSICAL THERAPY EVALUATION AND TREATMENT INCLUDE:

- Manual Lymphatic Drainage, Compression (Multi Layer Bandaging/Garments), Skin Care, &/or Therapeutic Exercises, Education
- Compression Pump/Devices
- Wound Care
- Evaluate and Recommend for Hyperbaric Oxygen Therapy

 Physicians Signature

 Date

Thank you for allowing us to participate in the care of your patient.

Frank Aviles Jr, PT, CWS, CLT-LANA Helen Gelly, MD David Schwegman, MD

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