COMMUNITY MEDICAL CENTERS

HYPERBARIC OXYGEN THERAPY

PATIENT REFERRAL FORM

If you feel your patient could benefit from HBO Therapy,
please complete information below ***and***

Fax this form with the requested information to: (559) 459-7043

DATE: _____

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ ZIP: _____ COUNTY: _____

PHONE: _____

PAYER SOURCE: _____

DIAGNOSIS: _____

REFERRING PHYSICIAN: _____ PHONE: _____

FAX: _____

HYBERBARIC OXYGEN
THERAPY DEPARTMENT
(559) 459-3870

FOR EMERGENT REFERRALS
COMMUNITY REGIONAL MEDICAL CENTER
LEON S. PETERS BURN CENTER
(559) 459-4220

COMMUNITY REGIONAL MEDICAL CENTER