OXYGEN & LIGHT

Date: _____ Name: _____

DOB: _____ Reasons for HBOT Referral: _____

Referring clinic or clinician: _____

_____

Other Medical Conditions: _____

Does the patient have any MOBILITY issues? ____ No _____ Yes (Describe) _____

Allergies: _____

Is the patient currently taking any of these **medications: INITIAL: _____ YES / _____ NO**

Bleomycin Cisplatin Disulfiram Doxorubicin Sulfamylon

Do they currently have any of the **following conditions** UNTREATED PRIOR TO THERAPY (i.e., if you are treated and they are not symptomatic these may not be an issue.)? **INITIAL: _____ YES / _____ NO**

Asthma ***Seizures*** ***Claustrophobia*** ***Upper respiratory infection (URI)***

Chronic obstructive pulmonary disease (COPD) ***High fever*** ***Unresolved pneumothorax***

Do they currently have any of the following which may modify HBOT therapy? **INITIAL: _____ YES / _____ NO**

Congenital spherocytosis ***Eustachian tube dysfunction*** ***Pacemakers or epidural pain pump*** ***Pregnancy***

****** Note:*** *Most surgical drains are compatible. Some implanted pumps are, and some oar not. Please call to discuss compatibility with HBOT.*

****** AIR TRAVEL:*** *While lower pressure HBOT is generally safe, patients should not fly for 24 hours after an HBOT dive.*

HBOT Rx:

PRESSURE: _____ 0.5 to 3 ATA TIME: _____ 30 to 120 minutes FREQUENCY: _____ 1 to 5 HBOT per Week

---

Any other questions, information, or detail you would like to share? _____

_____

_____

_____