HYPERBARIC MEDICINE REFERRAL - HBOT

UNDER 2 PRESSURE

Patient Name: _____

OHIP # _____ Version Code _____

DOB: _____ Gender: _____

Patient Phone #: _____

Alternative Phone #: _____

1692 Lakeshore Rd W, Mississauga ON L5J 1J5 Phone: 905-274-2032 Fax: 905-274-4067

email: info@underpressurehbot.ca

Consultations are done on Week Days

Date	Referring Physician Name	**OHIP** Billing #	Physician Signature
_____	_____	_____	_____

OHIP Covered HBOT Conditions

Chronic Non-Healing Wound *(wound present for more than 3 weeks)*

- ☐ Arterial/Venous Ulcers
- ☐ Diabetic
- ☐ Thermal Burns

Other ☐ _____

MANDATORY

RECENT ACCURATE SWAB RESULTS *from* ***within 4 weeks of this Referral MUST*** *be provided for* ***ALL*** *non-healing Wound Patients* ***PRIOR*** *to Consultation*

- Does the patient have a non-healing wound (present 3 weeks or longer)? Yes / No If **Yes**, is wound infected? Y / N
- Does the patient have an infection from another source? Yes / No If **Yes**, Source:
- Is patient institutionalized (long-term or permanent resident in hospital, CCC (Complex Continuing Care) unit, rehab institute or LTC facility? Yes / No
  - If **Yes**, is there known current or past history of antibiotic resistant infection? (MRSA / VRE / CRE / ESBL / other _____) Yes / No
  - If **Yes**, is patient currently receiving antibiotics for this? Yes / No

If Y has been selected for any of the above, please provide dates, pertinent documentation, follow up status

Delayed Radiation Injury

- ☐ Hemorrhagic Cystitis
- ☐ Radiation Proctitis
- ☐ Osteo Radionecrosis
- ☐ Other *(please describe)*
- ☐ Soft Tissue

Idiopathic Sudden Sensorineural Hearing Loss (ISSNHL) *** Please attach audiology reports*

☐ *(ISSNHL MUST be diagnosed by ENT with treatment (including HBOT) started within 14 days of* ***Original Diagnosis)***

- ☐ Exceptional Blood Loss
- ☐ Air / Gas Embolism
- ☐ Compartment Syndrome
- ☐ Decompression Sickness
- ☐ Intracranial Abscess
- ☐ Gas Gangrene
- ☐ Compromised skin flaps/grafts
- ☐ Osteomyelitis (refractory)
- ☐ Carbon Monoxide and/or Cyanide Poisoning
- ☐ Crush Injury / Acute Traumatic Ischemias
- ☐ Necrotizing Soft Tissue Infection *(including muscle fascia)*

Diagnosis/Condition Not Covered by OHIP - *please provide brief description*

Provide diagnosis and/or notes of condition seeking treatment for: *(anything not under OHIP listed above)*

If available, please also send Past Medical History, Medication List, Blood Work, Radiology (CXR, CT scan report, bone scan), Pathology, Microbiology, Urine Tests, Other (Specialist Notes, Studies)