CANORA MEDICAL & HYPERBARIC CLINIC

15803 100A Avenue
Edmonton, AB T5P 0L7
Tel: (780) 444 - 0779
Fax: (780) 705 - 0043
Email: canorahyperbaric@shaw.ca

HYPERBARIC OXYGEN THERAPY REFERRAL FORM

PATIENT INFORMATION

Last Name: ______________________ **First Name:** ______________________

PHN: ______________________ **DOB: (mm/dd/yy)** _____/_____/____ **Sex: (M/F)** ________

Address: ______________________ **City/Province:** ______________________

Primary Phone #: ______________________ **Secondary Phone #:**______________________

Only patients aged 14 and above are eligible for hyperbaric treatments. Also, the patient should be able to follow verbal commands.

DIAGNOSIS

- ☐ **Diabetic Ulcer of the Lower Extremity (Wagner Grade III, IV or V, not healed after 4 weeks)**
- ☐ **Chronic Refractory Osteomyelitis/Necrotizing Soft Tissue Infections**
- ☐ **Preservation/Preparation of Compromised Skin Graft/Flap**
- ☐ **Arterial Insufficiency with Ulceration**
- ☐ **Crush Injury, Compartment Syndrome, and Other Acute Traumatic Ischemia**
- ☐ **Burns**
- ☐ **Therapeutically Irradiated Patients Requiring Osseointegrated Implants**
- ☐ **Late Radiation Injury (Radiation Tissue Damage, Osteoradionecrosis)**
- ☐ **Other (Not Covered by AHC Insurance):** ____________________

PAST MEDICAL HISTORY

History: ____

____

Medications: ____

____

Hx of Seizures: Y/N _____ **Hx of Pneumothorax: Y/N** _____

ETOH use: ____

Narcotics use: ____.

Implantable devices: Y/N (if yes, specify type/manufacturer)

____

PLEASE FAX COMPLETED FORM TO:

(780) 705 - 0043

PHYSICIAN SIGNATURE

Physician Name: ______________________________

Date: (Y)_______ **(M)**_______ **(D)**_______

Physician Signature: ______________________________