MO2R Medical Oxygen Research

Hyperbaric Medicine Unit

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A. Wayne Evans, MD - Medical Director

*Please **FAX** this **Referral Form** to us at*
(416) 444-0202

http://www.mo2r.ca

Ref. Date _____

Patient Information:

Last Name: _____ First Name: _____

DOB (dd/mmm/yy): _____/_____/_____ Phone:_____ Alt_____

Reason for Referral: **Delayed Radiation Injury** Onset (date): _____ or 1 2 3 4 5 6 Dy Wk Mo ago

Cystitis ☐ Proctitis ☐ Osteoradionecrosis ☐ Ulcer ☐ Fibrosis ☐ Other _____

Primary Oncologic Dx: _____ T __ N __ M __

Surg Rx: ☐ _____ Systemic Rx [chemo]: ☐ _____ Radiotherapy (Finish Date): _____

Presentation:

Associations: Analgesia / Pain Management Bleeding /transfusion Infection

RLE Management to date: Adjunctive Rx:

Triage: Elective ☐ Semi - urgent ☐ Urgent ☐

Doctor Information:

Referring Physician: _____ Signed _____

Specialty_____ Phone: _____ OHIP# _____

Note: Pre-treatment Requirements generally focus on cardiopulmonary status & infection, thus please provide recent CXR / ECG / spirometry / wound cultures if known.

If any questions please call us at ph 905 614-0057. Thank you !