Hyperbaric Services

A.Wayne Evans, MD – Medical Director
4619 Burgoyne Street Mississauga, ON L4W 1G3

www.mo2r.ca

T/F: 1.833.440.0202

Patient Information

Ref. Date __________________

Last Name: _________________________________ First Name: _____________________________

DOB (dd/mmm/yy): ______/______/______ Phone:____________________ Alt________________

HCN ____________________________

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 (416) 444-0202 or Toll Free 1-833-440-0202
info@mo2r.ca Thank you !