Hyperbaric Services

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Medical Director

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Dixie/Eglinton Area

Patient Information Ref. Date _____

Last Name: _____ First Name: _____

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

HCN _____

Reason for Referral: Problem Wound ☐ Osteomyelitis ☐ Flap/Graft failure ☐

Delayed Radiation Soft Tissue Injury ☐ Osteoradionecrosis ☐ Acute Hearing Loss ☐ Perioperative: Y/N

Date of Onset: _____ / 1 2 3 4 5 6 Dy Wk Mo ago

Presentation _____

_____

Underlying / Comorbidity: Immunosup/SLE/ Scler/ DM Cx: Neuro ☐ Pulm ☐ PVD ☐ Renal ☐ CAD ☐

Management to date:

Associations: Analgesia / Pain Management ☐ Bleeding ☐ Infection ☐

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 Or Toll Free 1-833-440-0202.
info@mo2r.ca Thank you !

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