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: **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 !