Dynamic Health TECHNOLOGIES

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Hyperbaric Oxygen Chamber Assessment and Prescription

Client Name	LAST NAME	FIRST NAME		MI		**Today's Date**	
Address	Street/PO Box	City		ST	Zip	**Date of Birth**	
Primary Phone	( ) -				Circle: cell work home		
Secondary Phone	( ) -				Circle: cell work home		

Relevant Medical History

Vital Signs	**BP**		**PULSE**		**RESP**		**TEMP**			
Pain Rating (circle one)	0 (none)	1	2	3	4	5	6	7	8	9	10 (worst)
If pain rating greater than 3, please explain:										
Is this client receiving concurrent administration of doxorubicin (Adriamycin, Caelyx, Rubex)**, cisplatin** (Platinol, Platinol AQ, CDDP)**, or disulfiram** (Antabuse)**?**								Yes		No

Condition	**Yes**	**No**		**Yes**	**No**
Otitis Media			If yes, is this condition still present?		
Serous Otitis			If yes, is this condition still present?		
Fluid in Sinuses			If yes, is this condition still present?		
History of Pneumothorax			If yes, HBOC is **NOT considered appropriate** for this client		
History of Hemothorax			If yes, HBOC is **NOT considered appropriate** for this client		
History of Chest Tube			If yes, HBOC is **NOT considered appropriate** for this client		
COPD/Emphysema			If yes, HBOC is **NOT considered appropriate** for this client		
Epistaxis			If yes, will you approve for HBOC therapy?		
Other Pulmonary Conditions			Please describe:		
			If yes, is this condition still present?		

I, the prescribing practitioner, verify that this client named above may receive treatments of low pressure (ATA 1.3 or less) Hyperbaric Oxygen, an FDA Class II medical device approved for home use, according to the following:

ALL THREE SECTIONS BELOW MUST BE COMPLETED

1) Prescription:

___ unlimited use as needed or requested by client up to one year from this date, OR
___20 ___30 ___ 40 ___50 ___60 HBOC sessions

2) I also request that the Hyperbaric Oxygen treatments are provided:

_____ With SUPPLEMENTAL oxygen (10L/min blow-by via O2 concentrator), OR
_____ With SUPPLEMENTAL oxygen (___L/min by mask via O2 concentrator), OR
_____ Without SUPPLEMENTAL oxygen

3) HBOC is prescribed for the above client for:

___ the promotion of wellness AND/OR
___ diagnosis(es) of_____

Signature of Prescribing Practitioner: _____ Date_____

Prescriber's Address: _____ Phone #:_____