

HYPERBARIC MEDICINE REFERRAL - HBOT



Patient Name: _____	
OHIP # _____	Version Code _____
DOB: _____	Gender: _____
Patient Phone #: _____	
Alternative Phone #: _____	

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 email: info@underpressurehbot.ca

Consultation Days are Monday, Tuesday, Wednesday and Thursday ONLY

_____	_____	_____	_____
Date	Referring Physician Name	OHIP Billing #	Signature

OHIP Covered HBOT Conditions

Chronic Non-Healing Wound (*wound present for more than 3 weeks*)

<input type="checkbox"/> Arterial/Venous Ulcers <input type="checkbox"/> Diabetic <input type="checkbox"/> Thermal Burns Other <input type="checkbox"/> _____	<p>MANDATORY</p> <p>RECENT ACCURATE SWAB RESULTS from within 4 weeks of this Referral MUST be provided for ALL non-healing Wound Patients PRIOR to Consultation</p>
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- Does the patient have a non-healing wound (present 3 weeks or longer)? Yes / No If **Yes**, is wound infected? Y / N

- Does the patient have an infection from another source? Yes / No If **Yes**, Source: _____

- Is patient institutionalized (long-term or permanent resident in hospital, CCC (Complex Continuing Care) unit, rehab institute or LTC facility)? Yes / No

- If **Yes**, is there known current or past history of antibiotic resistant infection? Yes / No
 (MRSA / VRE / CRE / ESBL / other _____)

- If **Yes**, is patient currently receiving antibiotics for this? Yes / No

If Y has been selected for any of the above, please provide dates, pertinent documentation, follow up status

Delayed Radiation Injury

<input type="checkbox"/> Hemorrhagic Cystitis	<input type="checkbox"/> Soft Tissue
<input type="checkbox"/> Radiation Proctitis	<input type="checkbox"/> Other (<i>please describe</i>)
<input type="checkbox"/> Osteo Radionecrosis	

Idiopathic Sudden Sensorineural Hearing Loss (ISSNHL)

(*ISSNHL MUST be diagnosed by END with treatment (including HBOT) started within 14 days of Original Diagnosis*)

<input type="checkbox"/> Exceptional Blood Loss	<input type="checkbox"/> Compromised skin flaps/grafts
<input type="checkbox"/> Air / Gas Embolism	<input type="checkbox"/> Osteomyelitis (refractory)
<input type="checkbox"/> Compartment Syndrome	<input type="checkbox"/> Carbon Monoxide and/or Cyanide Poisoning
<input type="checkbox"/> Decompression Sickness	<input type="checkbox"/> Crush Injury / Acute Traumatic Ischemias
<input type="checkbox"/> Intracranial Abscess	<input type="checkbox"/> Necrotizing Soft Tissue Infection (<i>including muscle fascia</i>)
<input type="checkbox"/> Gas Gangrene	

Diagnosis/Condition Not Covered by OHIP - *please provide brief description*

Provide diagnosis and/or notes of condition seeking treatment for:

If available, please also send Past Medical History, Medication List, Blood Work, Radiology (CXR, CT scan report, bone scan), Pathology, Microbiology, Urine Tests, Other (Specialist Notes, Studies)