HBOT
CLINICS INC.

HRN: | Site: | DOB: yyyy/mon/dd
Last Name: | First and Additional Names:
PHN: | Gender: | Age in Years:
Admitting Physician: | Encounter #:
Address: Street, City Province, Postal Code
Telephone Number:
Date of Admission: yyyy/mon/dd | Family Physician:

HYPERBARIC OXYGEN THERAPY REFERRAL FORM

Please provide as much detail as possible to ensure your patient is assessed appropriately

Date: yyyy/mon/dd

Specialty/Clinic:

Refering physician/source:

Prac ID:

Address:

Phone:

Fax:

Family physician:

Specialists seen previously:

Alternate contact if patient unavailable:

Acceptable to contact re. booking: ☐ Yes ☐ No

Prior hospital admissions (past 2 years) **- Site(s):**________________________

Currently hospitalized where:____

Reason for referral:

Past medical history:

Current medications (provide doses and frequency for all listed) **and/or medication allergies:**

Urgency of referral:
- ☐ Emergent
- ☐ Urgent
- ☐ Routine

(see reverse for definition)

Requested action:
- ☐ Confirm &/or advise as to diagnosis
- ☐ Suggest Medication or management
- ☐ Assume management for this problem and return patient after care
- ☐ Provide telephone consultation
- ☐ Education for the patient

Type of referral:
- ☐ New referral
- ☐ Re-referral
- ☐ 2nd opinion

Investigations required for assessment
(include all relevant documentation available)
- Bloodwork
- Diagnostic imaging
- Consultant letters
- Discharge summaries
- Microbiology

Booking information:
Direct appointment by which of the following:
- ☐ Assign to next available appointment, or if no, by:
  - ☐ Specific physician_______________________________________(name)
  - ☐ Site:____

Factors that may affect consultation/care:
- ☐ Language spoken____
- ☐ Physician Limitations______________________________________
- ☐ Psychological____
- ☐ Economic____
- ☐ Other____

Is this patient a WCB or insurance patient? ☐ Yes ☐ No

Signature:____**Designation:**____**Date:**yyyy/mon/dd

Fax this form and all relevant investigations to HBOT Clinics 403-509-4744

Triage Category	Including but not limited to	Process	Approximate time to be seen
Emergent	• Decompression illness (serious) • Compartment syndrome (limb threatening) • Necrotizing soft tissue infection (critical) • Carbon monoxide poisoning and smoke inhalation (serious) • Cerebral arterial gas embolism • Exceptional blood loss (anemia) • Crush injury (limb-threatening) • Clostridial myonecrosis (gas gangrene)	Contact 24-hour emergency line: **403-509-4742**	Same day
Urgent	• Decompression illness (minor symptoms) • Crush injury or other acute traumatic ischemia (non-limb threatening) • Necrotizing soft tissue infections (non-critical) • Certain invasive fungal infections (e.g.,Mucormycosis) • Hemorrhagic cystitis (significant blood loss) • Thermal burns (serious)	Fax referral to: **403-509-4744**	Within 1 – 2 days
Routine	• Selected non-healing wounds (e.g., diabetic lower extremity) • Osteoradionecrosis • Soft tissue radiation injury	Fax referral to: **403-509-4744**	Within 1 week

Specific co-morbidity information to identify if relevant:	Specific symptom/patient information to identify if relevant:
• Diabetes • COPD • Asthma • Malignancy • Chronic ear or sinus condition	• History of pneumothorax • Smoking • History of chest surgery • Chemotherapy (specify) • History of seizures

Specific tests/investigations required to support triage:

- Provide all considered relevant by the referring source.
- HBOT Clinics encourages referring physicians to discuss atypical problems or uncertain diagnoses with the hyperbaric physician responsible for triage **(403-509-4740)**.

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