

HYPERBARIC OXYGEN THERAPY REFERRAL FORM

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:

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

Date: yyyy/mon/dd		Specialty/Clinic:	
Referring physician/source:		Prac ID:	
Address:		Phone:	
		Fax:	
Family physician:		Prac ID:	
Alternate contact if patient unavailable: Acceptable to contact re. booking: <input type="checkbox"/> Yes <input type="checkbox"/> No		Specialist seen previously & when:	
		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: <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent <input type="checkbox"/> Routine (see reverse for definition)	Requested action: <input type="checkbox"/> Confirm &/or advise as to diagnosis <input type="checkbox"/> Suggest Medication or management <input type="checkbox"/> Assume management for this problem and return patient after care <input type="checkbox"/> Assume future management of patient within area of expertise <input type="checkbox"/> Provide telephone consultation (if considered appropriate by specialty) <input type="checkbox"/> Education for the patient		Type of referral: <input type="checkbox"/> New referral <input type="checkbox"/> Re-referral <input type="checkbox"/> 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: <input type="checkbox"/> Assign to next available appointment, or if no, by: <input type="checkbox"/> Specific physician _____ (name) <input type="checkbox"/> Site: _____ Factors that may affect consultation/care: <input type="checkbox"/> Language spoken _____ <input type="checkbox"/> Physician Limitations _____ <input type="checkbox"/> Psychological _____ <input type="checkbox"/> Economic _____ <input type="checkbox"/> Other _____ Is this patient a WCB or insurance patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Decompression illness (minor symptoms) • Crush injury, compartment syndrome, or other acute traumatic ischemia (non-limb threatening) • Necrotizing soft tissue infections (non-critical) • Certain invasive fungal infections (Mucormycosis) • Hemorrhagic cystitis (significant blood loss) • Thermal burns 	Fax referral to: 403-509-4744	Within 1 – 2 days
Routine	<ul style="list-style-type: none"> • Selected non-healing wounds (diabetic) • 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:	
<ul style="list-style-type: none"> • Diabetes • COPD • Asthma • Malignancy • Chronic ear or sinus condition 		<ul style="list-style-type: none"> • History of pneumothorax • Smoking • History of chest surgery • Chemotherapy (specify) • History of seizures 	
Specific tests/investigations required to support triage:			
<ul style="list-style-type: none"> • 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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