Northern Nevada Hyperbarics, Inc.

Patient Information Sheet

Patient's Name:_____ Consult Date:_____

Birth Date:_____ Sex:_____

Social Security Number:_____ Condition:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work/Cell Phone:_____

Marital Status:_____ Spouses Name:_____

Employer:_____ Occupation:_____

Employers Address:_____

Primary Insurance:_____

Secondary Insurance:_____

Referring Physician:_____

Address:_____ Phone:_____

Emergency Contact:_____ Relationship:_____

Phone Number:_____

_____

Patient Signature

Notes:_____

_____

_____

Northern Nevada Hyperbarics, Inc.

To our patients;

We of Northern Nevada Hyperbarics wish to afford you the best possible care for your problem(s). In order to help us , we would appreciate your cooperation in filling out the following questionnaire. This will help us with decisions for your treatment.

Systems Review:

If you have any of the following please circle yes and give description. For example when diagnosed, frequency, duration, ect.

Head

Headache Y/N _____

Fainting Y/N _____

Stroke/ TIA Y/N _____

Weakness in extremities Y/N _____

False teeth/Bridge Y/N _____

Eyes

Glasses/Contacts Y/N _____

If yes Near sighted___ or Far sighted____

Double Vision Y/N _____

Cataracts Y/N _____

Glaucoma Y/N _____

Nose

Sinus Congestion Y/N _____

Sinus problems Y/N _____

Deviated Septum Y/N _____

Facial Injuries Y/N _____

Bleeding Y/N _____

Ears

Tinnitus Y/N _____

Impacted Cerumen Y/N _____

Hearing Aids Y/N _____

Drainage Y/N _____ Ear tubes Y/N _____

Ear infections Y/N _____

Lungs

Shortness of breath? Y /N _____

Cough? Y/N _____

Cough up blood? Y/N _____

Asthma? Y/N _____

COPD? Y/N _____

Pneumothorax (collapsed lung) Y/N _____

Lung Cancer Y/N _____

Breast Cancer Y/N _____ Mastectomy Y/N _____

Heart

Enlargement Y/N _____

Heart Surgery Y/N _____

Swelling of ankles Y/N _____

Chest pain Y/N _____

Angina Y/N _____

Dizziness Y/N _____

Fatigue Y/N _____

Rheumatic Fever Y/N _____

Irregular Heartbeat Y/N _____

Congenital problems Y/N _____

Heart Attack Y/N _____

Heart Murmur Y/N _____

Hypertension Y/N _____

Bleeding Y/N _____

Hardening of the arteries Y/N _____

Intestinal Tract

Gas Y/N _____

Indigestion Y/N _____

Belching/Burping Y/N _____

Change in bowel habits _____

Constipation? Y/N _____

Diarrhea? Y/N _____

Neck

Full range of motion Y/N _____

Neck/Shoulder pain Y/N _____

Cracking/popping with motion Y/N _____

Thyroid enlargement Y/N _____

Radiation exposure Y/N _____

Dysphasia Y/N _____

Endocrine

Diabetes Y/N Type _____ Taking Insulin Y/N Dose_____ Frequency _____

Thyroid problems Y/N _____

Hepatitis Y/N Type_____

Aids or HIV Y/N_____

Genito-Urinary

Burning with urination Y/N _____

Pain Y/N _____ Bleeding Y/N _____

Radiation exposure Y/N _____

Prostate /Bladder Cancer Y/N _____

Ovarian Cancer Y/N _____

Uterine/Cervical Cancer Y/N _____

Hysterectomy Y/N Full or partial_____

Pregnant Y/N _____ Breast Feeding Y/N Birth Control Y/N LMP_____

Neurological

Numbness/Tingling Y/N _____

Depression/Anxiety Y/N _____

Cognition problems Y/N _____

Musculoskeletal

Joint pain Y/N _____

Broken bones Y/N _____

Gout Y/N _____

Torn Muscles/Tendons Y/N _____

Arthritis Y/N _____

Prosthesis Y/N _____

Social History

Do you currently smoke Y/N How much? _____ How long? _____

Do you drink alcohol? Y/N _____ How often? _____ How much? _____

Recreational drug use Y/N Type_____ How often_____ IV_____

Dietary restrictions Y/N _____

Medications

Any known allergies _____ Reactions? _____

Please list your current medications and any you have taken in the last 3 months.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Informed Consent for Hyperbaric Oxygen Therapy

I, _____ give my consent to Northern Nevada Hyperbarics to administer Hyperbaric Oxygen Therapy. In doing so, I acknowledge that I have been advised of the following:

Although Hyperbaric Oxygen Therapy is considered a generally accepted and primary therapy for conditions such as non-healing wounds, radiation complications, decompression sickness, gas gangrene and carbon monoxide poisoning, its use is still considered "investigational" by many physicians when used to treat certain conditions such as stroke, Lyme disease, and others.

Thus, if I agree to be treated with Hyperbaric Oxygen Therapy for an investigational condition not recognized by the medical community or the Food and Drug Administration, , I acknowledge that I understand that it may or may help and that Northern Nevada Hyperbarics has made no claim that it would be a cure or heal these investigational conditions.

Northern Nevada Hyperbarics will administer Hyperbaric Oxygen Therapy as treatment for the following condition(s): _____

_____

Risk and Possible Side Effects:

1. Barotraumas or Ear and Sinus Discomfort: I may experience fullness and an uncomfortable pressure in my ears or sinuses. I understand that if I have difficulty equalizing the pressure in my ears or sinuses, pressurization will be stopped and suitable remedies will be applied.
2. Oxygen Toxicity: The risk of oxygen toxicity has been explained to me and will be minimized by never exposing me to greater pressure or longer times that are known to be unsafe for the body and its organs.
3. Serous Otitis: Rarely, fluid accumulates in the ears as a result of breathing high concentrations of oxygen. It may occasionally feel as if you have a "pillow over your ear". This disappears after Hyperbaric treatment ceases and can be eased with decongestants.
4. Temporary Worsening Of Near-Sightedness: It is possible that I may experience a temporary diminution in my ability to focus on things far away. I understand that this is temporary and that vision typically returns to its pre-treatment level about six weeks after cessation of Hyperabric treatment.

5. Numb Fingers: A small percent of patients sometimes notice a numb feeling in the fourth and fifth fingers of the hands after twenty or more treatments. This should not be of concern and should disappear within about six weeks following cessation of therapy.
6. Affect on Malignant Diseases: There are no studies to date that indicate whether Hyperbaric Oxygen Therapy will decrease, increase, or have any or no effect on malignant diseases such as cancer and tumor growth. I understand that Northern Nevada Hyperbarics can't be held liable for any changes that may occur coincidentally with treatment.
7. Pulmonary Barotrauma/Pneumothorax: There is a risk of spontaneous pneumothorax (collapsed lung) with increased atmospheric pressure such as a with Hyperbaric treatments.

This procedure and the reasons for it have been explained to me, including the benefits and possible complications/risks of treatment, along with the availability, risks, and benefits of alternative methods of treatment. I understand that I will lay on a stretcher in a Hyperbaric Chamber and breathe oxygen at greater than normal atmospheric pressure. I understand that each treatment will be for a prescribed amount of time and treatment may be terminated at any time.

I understand that no representation has been made to me by Nothern Nevada Hyperbarics, or any associate thereof, that treatments in which I hereby consent will produce any specific results or benefits. No representations are made except as set forth in this Informed Consent concerning the accuracy, validity or efficacy of Hyperbaric Oxygen Therapy.

My signature below acknowledges the following:

1. That I have read (or have had read to me) the forgoing;
2. Hyperbaric Oxygen Therapy has been explained to me by the HBO technician;
3. I am fully informed and consent to treatment.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Northern Nevada Hyperbarics, Inc.

Instructions for Patients Undergoing Hyperbaric Oxygen Therapy

Do NOT avoid or skip a meal prior to treatment.

Avoid all caffeine (coffee or tea), carbonated drinks, and alcohol for at least 24 hours prior to treatment.

Do NOT go into the chamber with any grease or oils on the skin (such as lotion) or hair.

No makeup, perfume, nail polish, false eyelashes, or products containing petroleum substances allowed on you before entering the chamber for treatment.

Please notify the Hyperbaric Technician if any medication is taken prior to treatment.

Remove all jewelry, wigs, and hair pins before entering the chamber.

Remove all prosthesis, hearing aids, contact lenses, glasses, or dentures/partials.

All clothing, including undergarments, must be removed and the technician will supply you with a gown made of 100% cotton daily. With the exception of an incontinent pad, only the gown is to be worn inside the chamber.

Because smoking, chewing and other uses of nicotine constrict the blood vessels, we ask you to stop smoking, and/or chewing tobacco while receiving hyperbaric treatments.

Do NOT take any foreign objects into the chamber with you.

Under no circumstances will you be allowed to receive hyperbaric treatments unless all the above conditions are followed. It is for the safety of all, that these conditions are met. Any materials other than what is specified, could be a fire hazard.

_____ _____

Patient Signature Date

_____ _____

Hyperbaric Technician Signature Date

Northern Nevada Hyperbarics, Inc.

1500 E. Second Street Suite 104
Reno, NV 89502
(775) 982-6290 Fax (775) 982-6293

Authorization for Release/Disclosure of Protected Health Information

Patient Name	Date of Birth	Social Security Number
Address		Phone
City, State, Zip Code		Fax
Name of Provider/Party Authorized to Receive Medical Records *Northern Nevada Hyperbarics*		
Address: 1500 E. Second Street Suite, 104		**Phone:** (775) 826-2084
City, State, Zip Code: Reno, NV 89502		**Fax:** (775) 826-2087

I authorize the release of following information* (check all applicable):

- ☐ Physician Generated Data
- ☐ H+P
- ☐ ER Documents
- ☐ Treatment/Office/Consult Notes
- ☐ Diagnostic Imaging Reports
- ☐ Pharmacy/prescription records

☐ Other (describe specifically)_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

_____ _____

Signature of patient (or patient's personal representative)

Date

_____ _____

Printed name of patient representative

Representative's authority to sign for patient, *(i.e parent guardian, power of attorney for healthcare, executor)*