Oxford Recovery Center

7030 Whitmore Lake Rd
Brighton, MI 48116
248.486.3636

165 Kirts Blvd Suite 500
Troy, MI 48083
248.247.3232

Patient Information and Medical History

General Information: Today's Date: _____

Name: _____ Birth Date: _____ Age____ Sex: M____ F ____

Street Address: _____City: _____State/ Zip: _____

Home Phone: _____ Cell: _____ Business: _____

E-mail Address: _____

Check: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment Status ___Full- time ____Part-time ___ Unemployed ___Disabled _____Retired _____ Minor

Emergency Contact _____ Relationship to Patient _____

Address: _____ _____Daytime Phone: _____

Referring Physician: _____Phone:_____

Street Address: _____City: _____State/ Zip: _____

How did you find out about Oxford Recovery Center?
__ Radio (WMUZ) Bob Dutko _____ Chris Stevenson_____ Robin/Mac _____
__ WJR (760 AM) Host: _____
__ Radio 1300 AM
__ Internet/Website
__ Physician Name_____ Specialty _____Phone_____
__ WDIV/Channel 4 commercial
__Friend/Relative
__Other

What is the primary reason for coming to Oxford Recovery Center?

_____

We enjoy talking with your family and/or caregivers about your progress. Is there anyone who accompanies you to your treatments that you do **NOT** want us to speak with regarding your progress:
No____ Yes____

_____
Name of family member or caregiver

All professional services rendered are charged to the patient. Necessary forms can be completed and provided to the patient to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

 Patient Information and Medical History

Responsible Party: (Person Responsible for Payment)
Same as above_____

Name_____ Relationship to patient: _____

Street Address: _____City: _____State/ Zip: _____

Are treatments covered by Auto Insurance? _____ Yes _____ No
Are treatments covered by Workers Compensation? _____ Yes _____ No

Physician:

Are you currently under a doctor's care? Yes ☐ No ☐

Physician's Name: _____ Specialty _____
Address: _____City _____ State _____Zip_____
Phone: _____ Fax: _____
Do you have a prescription for hyperbaric oxygen therapy? Yes ☐ No ☐

Advanced Directive

Do you have an Advanced Directive? Yes ☐ No ☐
If so we need all up-to-date signed documentation.

Social History

Tobacco Use: Never ____ Previously, but quit ____ Current packs/day_____
Caffeine Use: Never____ Type/Frequency _____
Alcohol Use: Never ____ Rarely ____ Moderate ____ Daily____
Drug Use: Never____ Type/Frequency_____

Patient's Medical History:

1. **CURRENT MEDICATIONS**: No _____ Yes _____ (Please list all medications prescribed and/or over the counter)

Medication	*Amount*	*How Often*

PATCH MEDICATIONS: (Please list NO_____ YES_____ (If YES, indicate name below)

_____

3. ALLERGIES (Please list all known allergies) _____

_____

2. DIABETES
   a. Do you have diabetes? yes/no (*Please circle one*)
   b. If yes, do you take: (*Please circle all that apply*) Insulin Oral agents Diet Controlled
   c. How often do you test your blood sugar? _____ times/day

3. PULMONARY/LUNG DIAGNOSIS

Have you ever been diagnosed with any lung/pulmonary condition, or pulmonary fibrosis? Yes_____ No_____

If yes, what is the condition/s: _____

Do you have any implanted devices? Yes_____ No_____

If yes, Please explain _____

 # Patient Information and Medical History

4. SEIZURE OR CONVULSION ACTIVITY

Are you experiencing seizures or convulsions or have you been told that you are at risk for seizures? Yes_____ No_____

If you have had or are currently having seizures or if you have been told that you are at risk for seizures please complete **Addendum B** of Patient and Medical History.

5. PREGNANCY STATUS

Are you pregnant or think you may be? ❑ Yes ❑ No

6. CURRENT HEALTH STATUS (Please check one for each item)

Body Pain	❑ None	❑ Some	❑ Severe
Wound Pain	❑ None	❑ Some	❑ Severe
Energy	❑ None	❑ Some	❑High
Physical Role Limitations	❑ None	❑ Some	❑ Severe
Emotional Role Limitations	❑ None	❑ Some	❑ Severe
Physical Functioning	❑ None	❑ Some	❑High
Social Functioning	❑ None	❑ Some	❑High
Mental Health	❑ Good	❑ Fair	❑ Bad
Health Perception	❑ Good	❑ Fair	❑ Bad

7. EAR HISTORY

Have you ever had ear problems? Yes ❑ No ❑

Explain_____

Do you have any problems with your ears when you fly? Yes ❑ No ❑

Do you have any problems going up and down in an elevator? Yes ❑ No ❑

Do you or have you ever done scuba diving? Yes ❑ No ❑

Do you have Hearing Aids? Yes ❑ No ❑

8. MEDICAL HISTORY

	PATIENT		FAMILY		EXPLAIN (Who, Age)
Diabetes	*Yes*	*No*	*Yes*	*No*	
Hypertension	*Yes*	*No*	*Yes*	*No*	
Cancer	*Yes*	*No*	*Yes*	*No*	
Stroke	*Yes*	*No*	*Yes*	*No*	
Bleeding	*Yes*	*No*	*Yes*	*No*	
Acute Infections	*Yes*	*No*	*Yes*	*No*	
Hereditary Defects	*Yes*	*No*	*Yes*	*No*	
Heart Trouble	*Yes*	*No*	*Yes*	*No*	
Arthritis/Gout	*Yes*	*No*	*Yes*	*No*	
Convulsions/ Seizures	*Yes*	*No*	*Yes*	*No*	

Patient Information and Medical History

9. VACCINE RECORD (10 YEARS OLD OR YOUNGER INCLUDE ALL, ADULTS LAST 5 YRS - Include influenza shots)

VACCINE	*DATE RECEIVED*

10. HOSPITALIZATION/SURGERY HISTORY (Please list all past hospitalizations)

Name of Hospital	*Purpose of Hospitalization*	*Date*

11. NUTRITION PROFILE (Please circle yes or no)

Do you take vitamins or other supplements? Yes No

If yes please list name, brand, amount and duration of time on supplement.

Supplement name	*Brand*	*Amount*	*How long taken*

How much water do you drink each day? _____ glasses

Do you exercise regularly? Yes No

Difficulty chewing or swallowing? Yes No

Assistance needed for eating? Yes No

Have you had a large weight loss? Yes No

Weight gain? Yes No

If yes, ____ lbs in ____ months

Reason if known_____

Special Diet? Please explain _____ Yes No

Food allergies? Please explain _____ Yes No

Are you involved in a weight loss program Yes No

Appetite: Good Fair Poor (Please circle one)

 Patient Information and Medical History

12. SYSTEM REVIEW (Please circle yes or no for each item)

GENERAL SYMPTOMS			*MUSCULOSKELETAL*		
Good health lately	*Yes*	*No*	*Joint pain*	*Yes*	*No*
Recent weight change	*Yes*	*No*	*Joint stiffness or swelling*	*Yes*	*No*
Headaches	*Yes*	*No*	*Weakness of muscles or joints*	*Yes*	*No*
EYES			*Back pain*	*Yes*	*No*
Blurred or double vision	*Yes*	*No*	*Cold extremities*	*Yes*	*No*
Glaucoma	*Yes*	*No*	*Difficulty in walking*	*Yes*	*No*
Cataracts	*Yes*	*No*	*Arthritis*	*Yes*	*No*
Currently getting shots in eye/s	*Yes*	*No*	*NEUROLOGICAL*		
EARS/NOSE/MOUTH/THROAT			*Frequent /recurring headaches*	*Yes*	*No*
Hearing loss or ringing	*Yes*	*No*	*Light headed or dizzy*	*Yes*	*No*
Earaches or drainage	*Yes*	*No*	*Convulsions or seizures*	*Yes*	*No*
Chronic sinus problems or rhinitis	*Yes*	*No*	*Poor sensation in feet*	*Yes*	*No*
CARDIOVASCULAR			*PSYCHIATRIC*		
Chest Pain	*Yes*	*No*	*Memory loss or confusion*	*Yes*	*No*
Swelling of feet, ankles or hands	*Yes*	*No*	*Depression*	*Yes*	*No*
Pacemaker	*Yes*	*No*	*Claustrophobia*	*Yes*	*No*
RESPIRATORY			*ENDOCRINE*		
Chronic or frequent coughs	*Yes*	*No*	*Glandular or hormone problems*	*Yes*	*No*
Spitting up blood	*Yes*	*No*	*Thyroid disease*	*Yes*	*No*
Shortness of breath	*Yes*	*No*	*Diabetes*	*Yes*	*No*
Asthma or wheezing	*Yes*	*No*	*Excessive thirst or urination*	*Yes*	*No*
Emphysema	*Yes*	*No*	*Heat or cold intolerance*	*Yes*	*No*
GASTROINTESTINAL			*LYMPHATIC*		
Frequent diarrhea	*Yes*	*No*	*Slow to heal after cuts*	*Yes*	*No*
Constipation	*Yes*	*No*	*Bleeding or bruising tendency*	*Yes*	*No*
INFECTIOUS DISEASES			*Anemia*	*Yes*	*No*
AIDS/HIV	*Yes*	*No*	*Phlebitis*	*Yes*	*No*
Hepatitis A	*Yes*	*No*	*GENITOURINARY*		
Hepatitis B	*Yes*	*No*	*Frequent urination*	*Yes*	*No*
Hepatitis C	*Yes*	*No*	*Incontinence/dribbling*	*Yes*	*No*

 Patient Information and Medical History

Notes or comments:

_____

_____

_____

_____

_____

I certify that the above Patient Information is true and accurate. I will advise Oxford Recovery Center if there is any change in Patient Information, Medical Problems, Allergies, Medications, Medical History, Insurance Information or any other pertinent item or condition related to my (or my child's) Hyperbaric Oxygen Therapy.
I further authorize the release of any medical or other information necessary for claim processing or on the request of physicians or providers involved in my care.

_____ _____

Signature of patient (Parent or guardian) Date

Review of Patient Information and Medical History

_____ _____

Signature of Oxford HBOT Tech Reviewer Date

_____ _____

Signature of Director Reviewer Date

Media Release

I authorize Oxford Recovery Center to take photographs, films, audio/or video, interview me or publish articles or appropriate medium now known, including internet with information about me for the purpose of documenting patient experiences, raising awareness of potential benefits of treatments and also for promotion of both Oxford Recovery and Oxford Recovery Kids foundation.

_____ _____

Patient Signature Print Name

Oxford Recovery Center

Instructions for Patients Preparing to take Hyperbaric Oxygen Therapy
HBOT **Safety** Requirements

Please Read Carefully, these will be strictly enforced.

- Only our 100% cotton gowns or scrubs will be allowed in the chamber. The patients may not wear any of their own clothing, except undergarments, into the chamber. Depends and feminine hygiene products are fine.
- Please remove watches and rings. This also includes the removal of prosthetic devices such as hearing aids, therma-care products.
- No heavy grease or oils on the skin or hair, such as, suntan lotion, perfumes, hairspray, fresh nail polish, fresh nail polish remover, heavy make-up, or strong scented deodorant.
- Smoking constricts the blood vessels we ask that you stop smoking while taking the treatments, or at least refrain for two hours prior to and after each treatment.
- Do not take any foreign objects into the chamber. This includes ANY WARMING DEVICE, such as hand warmer.
- Please advise the technician if you are not feeling well on the day of your treatment.
- Please advise the technician if you are having ANY discomfort during treatment.
- If you are a diabetic or hypoglycemic, please make sure you have something to eat before treatment.
- Please use the bathroom prior to your treatment, and refrain from drinking a lot prior to treatment.
- Please refrain from carbonated or gaseous foods two hours prior to treatment.
- Do not neglect to take your routine medications, including insulin prior to treatment.
- Please advise the technician if you are on ANY new medications, this includes any “patches.”
- If there are seizures or high temperatures prior to or in between treatments, please advise the staff before starting your treatment.
- For the safety of all patients, family members may not do anything to distract the technician during the treatments.
- Family members may not touch controls on the chamber for any reason.
- If an emergency occurs, such as an oxygen seizure, family member must not interfere with the treatment protocol. The patient will not be ascended until the seizure stops in order to protect them from a pneumothorax. As soon as the patient is off full oxygen and breathing ambient air the seizure will stop. (This is a very rare occurrence, and causes no permanent damage.)
- Please do not allow children unattended in the chamber room.
- Only one adult family member at a time will be permitted in the treatment area at a time. This policy is to ensure the safety of the patient. No children not being treated will be allowed in the chamber room.
- You must check with the chamber operator before bringing anything in the chamber.

THANK YOU FOR YOUR COOPERATION IN HELPING TO ENSURE SAFETY

Patient Name (Printed) _____

Patient/Guardian Name (Printed)_____

Patient/Guardian Signature_____ Date _____

Staff Signature _____ Date _____

Oxford Recovery Center

Hyperbaric Oxygen Contraindications

1. Physical contradictions:
   a. **Untreated pneumothorax or history of spontaneous pneumothorax**. This is a condition where air or gas is trapped in the fluid membrane surrounding the lungs. Of all contraindications this one is the absolute most serious.

      A patient presenting with an undrained pneumothorax in a pressurized hyperbaric chamber is always considered a concern. If the pneumothorax tensions at pressure, decompression will be extremely hazardous and potentially life-threatening. A patient with a pre-existing pneumothorax should have a chest tube inserted prior to pressurization. It is prudent to obtain a chest x-ray after the placement of a subclavian line, to rule out the occurrence of pneumothorax before a patient is pressurized in the chamber.
      Emphysema with carbon dioxide retention (COPD) This condition can lead to a pneumothorax during HBOT treatments. (see above)
      Patent Foramen Ovale in infants (A Heart Valve Congenital Defect)
2. Potential Side Effects:
   a. **Serous Otitis Media**: An acute or chronic collection of fluid in the middle ear, where fluid cannot drain down the Eustachian tube, either because of an upper respiratory infection or an attack of nasal allergy or from long standing Eustachian tube blockage. This fluid may have thickened so that it cannot be absorbed or drained easily. Hearing is diminished, similar to having "cotton in the ears." Normal hearing returns after a few weeks when the fluid is drained. Sinus decongestants may help alleviate the blockage.
   b. **Visual Refractory Changes:** Over multiple treatments, pressure can also temporarily affect the lens of the eye and vision may worsen or improve. Typically, patients with presbyopia may notice a vision improvement; those with myopia may notice blurriness. Each of these refractory changes reverts to pre-hyperbaric condition usually within 6 weeks after cessation of therapy.
   c. **Alternobaric Vertigo:** A sudden brief disorientation may occur when the pressure is reduced at the end of a treatment, especially if you get up very quickly.
   d. **Confinement Anxiety:** Rarely patients experiences anxiety during treatments. Calming techniques can be employed to reduce the anxiety and if necessary and appropriate, a mild sedative may be taken before treatment.
   e. **Numbness in fingers:** Very rarely tingling in the fourth and fifth fingers of the hands has occurred in a small percentage of patients. This disappears a few weeks after cessation of therapy.
3. Drug complications:
   a. **Doxorubicin** (**Adrianmycin**) **(AdrimycinR)** This is a chemotherapy drug. There is a three day waiting period after you have taken this drug to have it safely clear your body as cardiotoxicity may occur to treat at deep depths.
   b. **Disulfiram (AntabuseR)** This drug is used in treating alcoholism. It may impair the body's natural defense against oxygen toxicity. There is a seven day waiting period after you have taken this drug to treat at deep depths.
   c. **Cis-Platinum** This drug is used in cancer treatments. It impairs the wound healing. There is a seven day waiting period after you have taken this drug to have it safely clear your body. You may treat at 1.5 ata with it.
   d. **Mafenide Acetate (SulfamylonR)** This is an antibacterial cream used to suppress infection in burn patients. It can encourage CO_2 build-up, impairing wound healing. Patients using this cream should have all of the cream removed. Silver Sulfadiazene (FlamazineR) is an effective substitute and is compatible with HBOT.

4. Physical considerations:
    a. **High blood pressure**—Blood pressure will be taken before going into the chamber for people with uncontrolled blood pressure. HBO therapy acts as a vasoconstrictor because it slightly narrows or constricts blood vessels. This results in a patient's blood pressure can slightly raise during treatment. Therefore, if the patient's blood pressure is too high the patient may not be treated that day unless it is an emergency situation.
    b. **Pregnancy** (unless emergency such as CO_2 poisoning) There have been studies done in different stages of the pregnancy with no harm done to the fetus. However, more studies are needed in this area.
    c. **Diabetics:** Insulin levels need to be monitored before treatments. During the treatment the patient's sugar levels will decrease. If the level is too low prior to treatment, the patient will need to eat something in order to increase their level.
    d. **Dental:** All dental work, root canals, and fillings must be complete. A dental baro-trauma could occur causing a painful condition. Please let us know if you have any temporary dental caps or unfinished root canals.
    e. **Smoking**
    f. **Upper respiratory infections and chronic sinusitis**—usually patients can be treated comfortably by slow compression and decompression. Antihistamines, decongestants, and/or nasal spray may also give the patient relief.
    g. **Seizure disorders**—there are many studies showing seizures diminishing with HBOT; however this condition should be discussed with the Medical Director in order for extra care to be taken.
    h. **Implanted pacemaker-electronic**—these need to be checked with the manufacture for their pressure testing. Most implants are perfectly acceptable in a hyperbaric environment.
    i. **History of surgery for otosclerosis**, People who have otosclerosis have an abnormal sponge-like bone growing in the middle ear. This growth prevents the ear bones from vibrating in response to sound waves. Such vibrations are needed in order for you to hear.
    j. **History of optic neuritis**
    k. **Congenital spherocytosis** (An anemia disorder of the surface layer (membrane) of red blood cells.

Patient Name (Printed) _____

Patient/Guardian Name (Printed)_____

Patient/Guardian Signature_____ Date _____

Staff Signature _____ Date _____

Hyperbaric Oxygen Therapy Consent for Treatment

1. I (We) authorize and request the Hyperbaric Technologist and/or associates/assistants, to treat my condition using Hyperbaric Oxygen Therapy**.**
2. I (We) recognize that during the course of the treatments unforeseen conditions may necessitate additional or different procedures that are set forth. I (We) therefore authorize and request that the staff perform such procedure as are, in his/her professional judgment, medically necessary and appropriate.
3. The staff has explained to me (us) the nature of the procedures to be performed, the possible risks, discomforts and complications, the outcome hoped for, and the alternative treatments or procedures available. He/she answered all questions I (we) may have concerning the procedures.
4. I (We) understand and acknowledge that the following risks are associated with hyperbaric oxygen treatments: Barotrauma (to include ear squeeze, sinus squeeze and pulmonary overpressurization) with or without Pneumothorax, subcutaneous emphysema, or pneumomediastinum; visual changes; and sound injury to ears.
5. I (We) am aware that the practice of medicine is not an exact science and I acknowledge that NO GUARANTEES HAVE BEEN MADE TO ME (US) AS TO THE RESULT OF THE PROCEDURE.
6. I (We) understand that I (we) may withdraw this consent at any time.
7. I (We) have read, had explained to me (us), and understand the above consent. I (We) accept responsibility for the risks or complications which might occur during these procedures.
8. I acknowledge that I have been informed of the Notice of Privacy Practices. (HIPAA)
9. I acknowledge that I must give 24 hour notice if I am to miss an appointment. If I fail to do so, I acknowledge that I will be charged for the treatment for that day.
10. I am not pregnant and understand that I need to make the HBOT technician aware if this changes.
11. I acknowledge that if I discontinue treatment prior to completing the 40 treatment protocol, my treatments will be reallocated at the $195 rate instead of the discount rate and my refund of the unused portion will be in accord with that reallocation.

Patient Name (Printed) _____

Patient/Guardian Name (Printed)_____

Patient/Guardian Signature_____ Date _____

If Parent/Guardian is AUTHORIZED person to sign, please state relationship to patient: _____

12. I have discussed the procedure(s) with the patient (or other legally responsible person) and have advised him or her of the risks and alternative treatments of the procedure(s) and he or she has agreed to proceed.

Date:_____ Staff Signature:_____

Effective Date: 03/2010
Revised Date: 10/2018