Wound Care Center & Hyperbaric Medicine
Consent for Hyperbaric Oxygen Therapy

I, ________________________________, request that Dr. ________________________________ and his/her trained assistants perform the following procedure: HYPERBARIC OXYGEN THERAPY. I also agree to accept such other supportive and or additional care that his/her professional judgment may dictate during the above procedure.

1. DIAGNOSIS:

2. REASON FOR PROCEDURE: To increase the amount of oxygen available to the tissues to enhance wound healing, reduce edema and to improve the milieu for reducing bacteria in the wound.

3. ALTERNATIVES: Standard wound debridement, dressing changes, irrigation of the wound and addition of antibiotics or chemicals that reduce bacteria in the wound. These are the things done now. The use of Hyperbaric Oxygen Therapy is an additional therapy for treating wounds that augments the other methods of management.

4. RISKS: I have been made aware that possible risks or side effects of hyperbaric oxygenation include, but are not limited to:

   A. BAROTRAUMA or pain in the ears or sinuses – I may experience pain in my ears or sinuses. I also understand that if I am not able to equalize my ears or sinuses that pressurization will be slowed or halted and suitable remedies will be applied. I may require placement of tubes in my ears. There is a small risk of rupture of the eardrum or, in worse cases, a rupture of the oval window causing hearing loss or dizziness. Medications may be given to help with equalization of the pressures.

   B. CEREBRAL AIR EMBOLISM and PNEUMOTHORAX – Whenever there is a rapid change in ambient pressure, there is the possibility of rupture of the lungs with escape of air into the chest cavity outside the lungs. This can only occur if the normal passage of air out of the lungs is blocked during decompression. Slow decompressions are used in hyperbaric oxygen treatment to minimize this possibility. This may require a chest tube to treat.

   C. OXYGEN TOXICITY – There is a small risk of lung toxicity caused by the high oxygen pressure. There is a small risk of a seizure while breathing pure oxygen under pressure.

   D. RISK OF FIRE – With the use of oxygen in any form, there is an increased risk of fire, but precautions have been taken to prevent this and applicable codes have been complied with.

   E. RISK OF WORSENING NEAR–SIGHTEDNESS (Myopia) – After twenty or more treatments, especially if I am over forty, it is possible that I may experience diminution in my ability to see things far away. I understand that this is believed to be temporary and that vision usually returns to its pre–treatment level about six weeks after the cessation of therapy. I understand that it is not advisable to get a new prescription for my glasses until at least eight weeks have passed after hyperbaric therapy.
F. TOOTH SQUEEZE – Sometimes pressurized air or oxygen can get into an area of cavity, broken filling, cap, and/or site of old root canal and cause pressure after ascending and may require dental evaluation or treatment to release the pressure. This could cause discomfort or cost not expected.

5. PROBABILITY OF SUCCESS: Hyperbaric Oxygen Therapy has a very high probability of success in those patients who qualify for therapy. As with any mode of treatment there can be unexpected failures.

6. IF THE THERAPY IS NOT DONE: You may have a higher incidence of failure to heal the wounds risking a long term wound that won’t heal or progression of the wound that may require amputation. Some wounds will heal after a long time with other therapies.

I understand that Hyperbaric Oxygen Therapy consists of being in a chamber at higher than normal atmospheric pressure breathing 100% oxygen. Each treatment will last about 2 hours with at least 90 minutes of breathing 100% oxygen. The number of treatments may vary according to the diagnosis, but a typical therapy will be 20 to 30 treatments. There are circumstances that will alter the number of treatments and those circumstances will be explained as needed. The treatments may be terminated at the patient’s request at any time.

I have reviewed the above information and I have asked questions and they have been answered to my satisfaction. Furthermore, I understand there may be observers in the treatment room and that pictures may be taken for documentation purposes.

Patient: ___________________________  Date: ____________  Time: ____________

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