

Modern Medical Clinic

Hyperbaric Medicine Referral Form

898 Alloy Place Thunder Bay ON, P7B 6E6

Phone: 807-235-0071 Fax: 833-342-3789 Email: reception@mmclinic.ca

Patient Information

Last Name: _____ First Name: _____ Sex: M F Other

DOB (DD/MM/YY): _____ OHIP #: _____

Phone: _____ Alt phone: _____ Email: _____

Address: _____

Reason For Referral

Date of Referral: _____

- | | |
|--|--|
| <input type="checkbox"/> Non-healing Wound | <input type="checkbox"/> Intracranial Abscess |
| <input type="checkbox"/> <i>Diabetic Ulcer</i> | <input type="checkbox"/> Gas Gangrene |
| <input type="checkbox"/> <i>Non-healing Surgical Wound</i> | <input type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> <i>Venous or Arterial Ulcer</i> | <input type="checkbox"/> Necrotizing Soft Tissue Infection |
| <input type="checkbox"/> <i>Acute Arterial Ischemia</i> | <input type="checkbox"/> Thermal Burns/Frost Bite |
| <input type="checkbox"/> <i>Other: _____</i> | <input type="checkbox"/> Exceptional Anemia |
| <input type="checkbox"/> Delayed radiation injury | <input type="checkbox"/> Decompression Sickness |
| <input type="checkbox"/> <i>Radiation Proctitis</i> | <input type="checkbox"/> Air/Gas Embolism |
| <input type="checkbox"/> <i>Hemorrhagic Cystitis</i> | <input type="checkbox"/> Carbon Monoxide Poisoning |
| <input type="checkbox"/> <i>Soft Tissue Injury</i> | <input type="checkbox"/> Crush Injury/Compartment Syndrome |
| <input type="checkbox"/> <i>Osteoradionecrosis</i> | <input type="checkbox"/> Compromised Grafts and Flaps |
| <input type="checkbox"/> <i>Other: _____</i> | <input type="checkbox"/> Sudden Sensorineural Hearing Loss |

Other: _____

Brief History

Include With Referral

Medical History (*if applies)

- Past medical
 Medication list
 Wound care*
 Chemo or radiation*

Investigations

- Chest x-ray
 CBC, lytes, BUN, Cr, A1c, CRP
 ECG
 CT Thorax (*If pulmonary history*)

Triage

- Elective
 Urgent
 Emergent (*call*)

Pending Investigations - Copy to Dr. M Labine, note if pending in "brief history" and/or forward

Referring Provider: _____

Specialty: _____ Billing #: _____

Phone: _____ Fax: _____ Email: _____

Provider Signature: _____

Referrals sent to: reception@mmclinic.ca or Fax: 833-342-3789

For additional information: mmclinic.ca

Available on OCEANS eReferral Healthmap under Hyperbaric Therapy