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

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

Date of Referral: _____

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

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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