SOCAL HYPERBARIC OXYGEN CENTER

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PHYSICIAN/PRACTITIONER STATEMENT

Important! **This form must be filled by and MD, ND, DO, DC, or any other practitioner who licensed to recommend Hyperbaric Oxygen Therapy (HBOT) and brought with you to your appointment.**

Patient/Client Name:_____ Date of Birth:_____
I am willing to confirm that Mr./Mrs./Ms._____
at phone number (_____) is fit to be inside a Hyperbaric Chamber and approved for HBOT sessions, consisting of 60-minute sessions, one to two times daily (minimum of 3-4 hours apart), for the prescribed amount of total treatments. Additional oxygen via 100% medical grade gas supplier, may be used by facial mask or hood. Not to exceed 10 lpm or 14 lpm, respectively.

PLEASE SELECT ONE OF THE FOLLOWING:

☐ My patient/client has been diagnosed with_____ and I recommend:

HBOT at_____ ATA for total of_____ sessions.

ADDITIONAL COMMENTS:

_____

_____

_____

Practitioner's Name:_____ Date Signed:_____

Practitioner's Signature:_____ Practitioner's Phone:_____

Practitioner's Address:_____

Practitioner's Stamp/License #