



## INFORMED CONSENT FOR HYPERBARIC OXYGEN THERAPY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Proposed number of treatments: \_\_\_\_\_ \* (\*number of treatments might increase or decrease based on clinical progression.)

I hereby authorize MVS Wound Care and Hyperbarics. and its medical staff, to treat me with hyperbaric oxygen therapy as prescribed by the hyperbaric physician in a monoplace hyperbaric chamber. The nature and purpose of hyperbaric medicine has been explained to me and I hereby acknowledge that I understand the nature and purpose of these treatments. Additionally, I acknowledge the possible risks and side effects of hyperbaric oxygen therapy, including but not limited to those listed below. I have been given the opportunity to ask questions and have my questions answered by the hyperbaric physician.

**Barotrauma or pain in the ears or sinuses.** I may experience pain in the 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.

**Cerebral Air Embolism and Pneumothorax.** Whenever there is a rapid change in the ambient pressure, there is a possibility of rupture of the lungs with escape of air into the arteries or into the chest cavities outside the lungs. This only occurs if the normal passage of air out of the lungs is blocked during recompression. Only slow recompressions are used in hyperbaric oxygen therapy to obviate this possibility.

**Oxygen toxicity.** The risk of oxygen toxicity and seizures has been explained to me and will be minimized by never exposing me to greater pressure or longer times than are known to be safe for the body and its organs.

**Risk of fire.** With the use of oxygen in any form there is always a risk of fire, but strict precautions have been taken to prevent this and all applicable codes have been complied with.

**Risk of worsening of near-sightedness. (Myopia).** It is possible I may experience a decrease in my ability to see things far away. I understand that this is usually temporary and that in the majority of patients, vision returns to its pre-treatment level 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.

**Temporary improvement in far-sightedness. (Presbyopia)** It is possible that I may experience an improvement in my ability to see things close or to read without reading glasses. I understand that this could be temporary and that in the majority of patients, vision returns to its pre-treatment level about six weeks after the cessation of therapy. I have been cautioned not to be fitted for new eyewear prescriptions for eight weeks after the end of my treatments.

**Maturing or Ripening of Cataracts.** In individuals with cataracts, it has occasionally been demonstrated that there may be a maturing or ripening of the cataracts.

**Serous Otitis.** Fluid in the ears sometimes accumulates as a result of breathing high concentrations of oxygen. This disappears after hyperbaric treatment ceases and often can be eased with decongestants.

I am aware that the practice of medicine and surgery is not an exact science and I have been made no promises or guarantees as to the results of Hyperbaric Oxygen Therapy.

I have been informed by the staff of MVS Wound Care and Hyperbarics. that smoking cigarettes, pipes, cigars, or any other form of tobacco and the chewing of tobacco products will result in the ingestion of chemicals into the body which may affect the efficacy of success of hyperbaric treatment. I have been specifically told **NOT** to smoke during the entire duration of treatments.

I hereby authorize MVS Wound Care and Hyperbarics. or their employees to take medical photographs for the purpose of teaching or publication. I also understand that I will not be identified by name and that my anonymity will be preserved in any presentation or publication.

I consent to the release of information and /or disclosure of any part of my medical record by any physician, hospital, accreditation, or regulatory organization responsible for monitoring or evaluation health facilities as well as any other facility of which I have been a client.

I have read and agree to the information above. I have also, read and understand the Patient Safety Requirements and the products that are not allowed into the chamber at any time. I agree and understand the MVS Wound Care and Hyperbarics. has been satisfactorily explained to me. I hereby understand that I am entering into hyperbaric treatment at my own risk. I hereby give my authorization and consent to the performance of hyperbaric oxygen therapy by MVS Wound Care and Hyperbarics.

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Patient or Authorized Representative Date

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Hyperbaric Physician Date