BURNS INTEGRATIVE WELLNESS CENTER

Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

CERTIFIED BRAIN HEALTH COACH

Hyperbaric Oxygen [HbO2] Treatment Consent

Name: _____

Contraindications

Have you ever been diagnosed with, suffer from, or are curently being treated with/or for any of the following:

Y	N		Y	N		Y	N	
☐	☐	Congenital Spherocytosis	☐	☐	COPD with Emphysema	☐	☐	Claustrophobia
☐	☐	Emphysema with CO2 Retention	☐	☐	Untreated Pneumothorax	☐	☐	Viral Infection
☐	☐	Hx of Spontaneous Pneumothorax	☐	☐	Unvented Pneumothorax	☐	☐	Optic Neuritis
☐	☐	Implanted Devices [Pacemakers]	☐	☐	Acute Severe BronchospasmX	☐	☐	Diabetes
☐	☐	Current use of High Dose Steroids	☐	☐	Cis-Platinum [CA Agent]	☐	☐	Asthma
☐	☐	Hx of Ear, Nose, and Throat Surgery	☐	☐	Upper Airway Infection	☐	☐	Epilepsy
☐	☐	Uncontrolled Arterial Hypertension	☐	☐	Uncontrolled Heart Failure	☐	☐	Dangerous Behavior
☐	☐	Bleomycin AntiCA-Pulmonary Toxicity	☐	☐	Chronic Sinusitis and/or Otitis	☐	☐	High Blood Pressure
☐	☐	Hx of Pneumothorax or Thorax Surgery	☐	☐	Hx of Otosclerosis Surgery	☐	☐	Hx of Optic Neuritis
☐	☐	Upper Respiratory/Sinus Infection	☐	☐	Use of “Hard Contact Lenses"	☐	☐	Allergic Rhinitis
☐	☐	Doxorubicin [Adriamycin] Chemo Drug-cardiac toxicity				☐	☐	Seizure Disorders
☐	☐	Mafenide Acetate [Sulfamylon] Antibacterial-Periph CO2 Retention						

If YES to any of the above, please explain in detail:

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_____
Address

_____ _____ _____
City State Zip Code

_____ _____ _____
Signature Patient Patient Name [Printed] Date

_____ _____ _____ _____
If needed, Signature of authroized representative Representative Name [Printed] Relationship to patient Date

_____ _____
Authorized Facility Signature Date