



**INFORMED CONSENT FOR HYPERBARIC OXYGEN THERAPY, WOUND CARE, AND TRANSCUTANEOUS OXYGEN MONITORING**

For the Facility checked below:

- HyperbaRXs at DeKalb (d.b.a. DeKalb Hyperbaric Medicine & Wound Care Center)
- HyperbaRXs at Johns Creek
- HyperbaRXs at Kennestone (d.b.a. Cobb Hyperbaric Medicine)
- HyperbaRXs at Northside Forsyth (d.b.a. North Georgia Center for Hyperbaric Medicine & Wound Care)
- HyperbaRXs at Saint Joseph's (d.b.a. Hyperbaric Medicine of North Atlanta)

I, \_\_\_\_\_, hereby consent to and authorize this Facility and HyperbaRXs, and such assistants as may be designated, to perform or have performed on me, HYPERBARIC OXYGEN THERAPY, MYRINGOTOMY, and/or WOUND CARE, as required. Additionally, I consent to and authorize this Facility and HyperbaRXs, and such assistants as may be designated, to evaluate tissue oxygen content, and by extension the need for hyperbaric oxygen treatments with TRANSCUTANEOUS OXYGEN MONITORING, a non-invasive, topical procedure.

The nature and purpose of Hyperbaric Oxygen Therapy and/or Wound Care has been explained to me by:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Daniel Beless, MD | <input type="checkbox"/> Jann Blanton, MD   | <input type="checkbox"/> Melanie Cooper, MD  | <input type="checkbox"/> Mahesh Desai, MD |
| <input type="checkbox"/> Helen Gelly, MD   | <input type="checkbox"/> Belinda Marcus, MD | <input type="checkbox"/> David Schwegman, MD | <input type="checkbox"/> Ron Stephens, MD |
| <input type="checkbox"/> Marina Wilder, MD | <input type="checkbox"/> _____              |  |   |

\* \* \* \* \*

*This section pertains specifically to Hyperbaric Oxygen Therapy:*

I know and realize that Hyperbaric Oxygen Therapy might call for more than one treatment and I hereby authorize this Facility and HyperbaRXs, and such assistants as may be designated, to perform the number of Hyperbaric Oxygen Treatments which in their opinion are necessary to treat my condition.

I hereby acknowledge that I know and understand the nature and purpose of Hyperbaric Oxygen Treatments. Additionally, the physicians have explained to me the consequences, risks (listed below) and alternatives to receiving Hyperbaric Oxygen Therapy and have given me the opportunity to ask any questions I might have concerning this matter. Further, the physicians have answered my questions to my satisfaction.

Risks of Hyperbaric Oxygen Therapy:

1. Ear drum discomfort/rupture; sinus pain
2. Oxygen toxicity-central nervous system (seizures/fits), pulmonary irritation, nausea, tingling
3. Lung over pressurization/collapsed lung (pneumothorax); gas embolism (bubbles in bloodstream)
4. Myopia (reversible after HBO) (nearsightedness/ change in vision)
5. Increased cataract growth rate (thickening of lens/change in vision)
6. Increased risk of fire

\* \* \* \* \*

I hereby give my authorization and consent to the performance of Hyperbaric Oxygen Therapy and/or Wound Care.

\_\_\_\_\_  
(witness signature)

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(physician signature)

\_\_\_\_\_  
(date)



**INFORMED CONSENT FOR PHOTOGRAPHY**

*For the Facility checked below:*

- HyperbaRXs at DeKalb *(d.b.a. DeKalb Hyperbaric Medicine & Wound Care Center)*
  - HyperbaRXs at Johns Creek
  - HyperbaRXs at Kennestone *(d.b.a. Cobb Hyperbaric Medicine)*
  - HyperbaRXs at Northside Forsyth *(d.b.a. North Georgia Center for Hyperbaric Medicine & Wound Care)*
  - HyperbaRXs at Saint Joseph's *(d.b.a. Hyperbaric Medicine of North Atlanta)*
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I hereby grant permission to \_\_\_\_\_ to take medical photographs of my \_\_\_\_\_ and hereby authorize the publishing or reproduction of such photographs for correspondence with my referring physician and for teaching purposes. I also understand that I will not be identified by name and that my anonymity will be preserved in any presentation or publication.

Furthermore, I grant permission to \_\_\_\_\_ to take a photograph of myself for the purpose of patient identification. This photograph shall remain a permanent part of my patient record and will not be reproduced or published elsewhere without my consent.

\_\_\_\_\_  
*(witness signature)*

\_\_\_\_\_  
*(date)*

\_\_\_\_\_  
*(patient signature)*

\_\_\_\_\_  
*(date)*