THOMAS A. SULT, MD
3rd Opinion
New Questions Better Solutions

HYPERBARIC MEDICINE PATIENT CONSENT

I hereby authorize Dr. Tom Sult and such assistants as may be selected by him to treat me in the monoplace hyperbaric chamber and do all that is required as part of hyperbaric oxygen therapy.

If any unforeseen conditions arise during the course of this treatment, I do hereby authorize and request the physician and his assistants to perform such additional procedures and/or to render such treatment as he may in his professional judgement deem necessary.

The physician and a staff member has explained to me the general methods of the procedure, and explained to me the special risks, contraindications, and consequences associated with hyperbaric oxygen therapy. These include, but are not limited to:

- Barotrauma-which is trauma or squeeze to the ears, teeth, or sinuses due to pressure. This includes eardrum rupture, ear pain, sinus pain, tooth pain, and / or tooth rupture.
- Pulmonary over pressure- which is trauma to the lungs including shortness of breath, lung rupture or collapse, and pulmonary embolism (gas bubble in the lung).
- Changes to my vision, including blurred vision. Vision should return to my pre-therapy normal in six weeks.
- Oxygen toxicity seizures
- Claustrophobia
- Fire
- Other Complications that could lead to disability, disfigurement or death

In the event of an emergent situation, decompression will begin; however, I understand that the hyperbaric chamber requires a minimum of 2 minutes to decompress.

I understand and acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

I also consent to and authorize the administration of medication(s) to me, and I assume all risks in connection with the use of such medication.

I certify that I have read, or have had read to me, this consent and that I have had a chance to ask any questions regarding hyperbaric therapy. These questions have been answered to my satisfaction and I willingly give consent to receive hyperbaric oxygen therapy. I realize that the physician and his/her agents are not employees of UCH.

______________________________ ______________________________

(Signature of Patient) (Date)

*** When patient is a minor or unable to give consent***

______________________________ ______________________________

(Person Authorized to Consent) (Date)

______________________________ ______________________________

(Signature of Witness) (Date)

I have explained to the above patient or his/her legal representative, in layman's terms, the nature of the above procedure(s), possible alternative modes of treatment, possible risks, hazards, complications and consequences which are/or may be associated with the procedure(s).

______________________________ ______________________________

(Signature of Physician) (Date)

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