PHYSICIAN STATEMENT

IMPORTANT! THIS FORM MUST BE FILLED BY AN MD, ND, DO, OR DC WHO IS LICENSED IN THE STATE OF TEXAS TO RECOMMEND HYPERBARIC OXYGEN THERAPY (HBOT) AND BROUGHT WITH YOU TO YOUR APPOINTMENT ATX HYPERBARICS AND/OR SCANNED AND SENT

TO WESTLAKE@ATXHYPERBARICS.COM.

Patient 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 'typical hyperbaric program' which consists of 60 minute sessions at 1.3 ATA one to two times daily (minimum of 4 hours apart) consecutively for 5 days until a total of 40 hours is achieved. Oxygen concentrator may be used by facial mask or cannula, not to exceed 8 lpm or 3 lpm, respectively.

PLEASE SELECT ONE OF THE FOLLOWING:

☐ My patient wishes to use Mild-Hyperbaric Oxygen Therapy (MHBOT) for general health & wellness

☐ My patient has been diagnosed with _____ and I recommend: HBOT at _____ ATA for total of _____ sessions

☐ I do not recommend the use of Mild Hyperbaric Oxygen Therapy (MHBOT) for the reasons stated below:

_____
_____
_____
_____

Additional

Comments: _____
_____

Practitioner's Name:
_____ ___

Date Signed:
_____

Practitioner's Signature:
_____

Practitioner’s Phone:

_____

Practitioner’s Address:

_____

Practitioner’s Stamp/License#

_____