Hyperbaric Medicine Consult

RedCap # _____

Name	**MR#**
SS# (or last 4)	**Gender:** **Assess for pregnancy: Y/N**
Race: **Ethnicity:**	**Phone #:** **e-mail:**
DOB:	**Never smoker/current smoker/former smoker** **Quit date:**
Address: **Town/City:** **State:**	**Diabetic: Y/N** **PO Meds** **Insulin**
Zip: **Country:**	**Driving distance:** **(miles)**
Primary Insurance:	**Secondary Insurance:**
Pt. type (outpatient/inpatient):	**Date of referral:**
Year of referral (for registry):	**Age at time of referral:**
Referring physician:	**Pager/phone#:**
Referring specialty:	**Referring facility:**
Reason for referral:	**Urgent/non-urgent:** **Date of most recent chest X-ray:**
Allergies:	**Weight:**

Consult scheduled: _____

Consents signed: Treatment _____ Long Term follow-up _____