PATIENT IDENTIFICATION LABEL	Penn Medicine Chester County Hospital **Patient Consent to Hyperbaric Oxygen Therapy Wound Care Center**

Patient Name: _____ **Date of Birth:** _____

Hospital: _____

Patient hereby voluntarily consents to Hyperbaric Oxygen Therapy Treatment (referred to as "HBO Therapy") provided by the Hospital and the Wound Care Center and their respective employees, agents, representatives, and affiliated companies (hereinafter sometimes collectively referred to as the Wound Care Center – "WCC"). Patient understand that this Consent Form will be valid and remain in effect from the date of signature, as long as Patient receives care, treatment or services at the WCC. A new consent will be obtained when a patient is discharged from the WCC and returns for care, treatment, or services. Patient has a right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

1. General Description of HBO Therapy: Patient acknowledges that Physician has explained that HBO Therapy will consist of Patient being enclosed inside a Hyperbaric Oxygen Therapy chamber. While inside the chamber, Patient will breathe pure (100%) oxygen and the air pressures around Patient will be raised to two or three times what Patient normally experiences. This treatment will result in higher than normal levels of oxygen in Patient's blood and body tissues and this level will persist during treatment, and for variable times after treatment. Patient acknowledges that Physician has given Patient the opportunity to ask, Patient has asked, and Physician has answered all Patient's questions regarding HBO Therapy.

2. Benefits of HBO Therapy: Patient acknowledges that Physician has explained that the benefits of treatment include: enhanced wound healing and reduced risks of amputation and infection.

3. Likelihood of achieving goals: Patient acknowledges that Physician has explained that by following the physician's plan of care he or she is more likely to have a better outcome, however, any procedure/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Therefore, Patient specifically agrees that no representation made to him or her by Physician, Hospital or WCC constitutes a Warranty or Guarantee for any result or cure.

4. Alternative to HBO Therapy: Patient acknowledges he or she has been made aware that he or she may refuse treatment in the WCC. Patient acknowledges that if he or she refuses treatment, he or she will not gain the benefits of treatment (See **Benefit of Therapy** above). In lieu of treatment in the WCC, Patients may continue a course of treatment with his or her personal physician or forego any treatment.

5. Benefit of Alternative to HBO Therapy: Patient acknowledges that Physician has explained that if he or she chooses to continue a course of treatment with his or her personal physician or forego any treatment, he or she may not experience the risks/side effects associated with recommended HBO Therapy (see **Side Effects of HBO Therapy and Risks of HBO Therapy** below).

6. Risk/Side Effects of Alternative to HBO Therapy: Patient acknowledges that Physician has explained that the risks of alternative to HBO Therapy include prolonged healing or failure to heal, infection and possible amputation if wound is on a limb.

7. Side Effects of HBO Therapy: Patient acknowledges that Physician has explained that the side effects of HBO Therapy include but are limited to: irritation and even permanent changes in the lungs, stimulation of the nervous system causing temporary visual problems, ringing in the ears, muscular twitching, nausea, and convulsive seizures. Patient acknowledges that Physician has explained that since the therapy involves the change of pressure to which Patient is exposed, Patient's ears, sinuses, and lungs are subject to pressure related injury if the pressure cannot be adequately equalized.

PATIENT IDENTIFICATION LABEL	Penn Medicine Chester County Hospital **Patient Consent to Hyperbaric Oxygen Therapy Wound Care Center**

Patient acknowledges that Physician has explained that Hyperbaric Oxygen Therapy may have an effect on Patient's medication requirements (e.g. insulin, digitalis, etc.). Patients with diabetes may experience a drop in blood sugar during hyperbaric oxygen therapy that may require specific blood sugar monitoring and interventions to prevent or treat. In some patients with a history of severe congestive heart failure, hyperbaric oxygen therapy may make the condition worse producing pulmonary edema causing treatment to be discontinued. Should Patient undergo a long series of treatments, Patient may become a little more nearsighted for a month or so.

8. Risks of HBO Therapy: Patient acknowledges that Physician has explained that there are a series of medical conditions, which may interfere in the safe delivery of Hyperbaric Oxygen Therapy. Patient must inform Physician of any physical illness(s) including, but not limited to, any of the following conditions: untreated cancer, an untreated collapsed lung, a history of spontaneous collapsed lung, chronic sinusitis, upper respiratory infection (cold), chronic obstructive lung disease (known as emphysema, asthma, bronchitis, etc.), heart disease with congestive failure, high fever, history of chest or ear surgery, current viral infection (flu, etc.) and pregnancy. In addition, the oxygen environment in which the treatment occurs greatly increased the danger of fire which may cause serious injury or death.

The patient hereby acknowledges that he or she has read and agrees to the contents of sections 1 through 8 of this document. Patient agrees that his or her medical condition has been explained to him or her by the Physician. Patient agrees that the risks, benefits and alternatives to HBO Therapy have been discussed with Patient by Physician. Patient understands the nature of his or her medical condition, the risks, alternative and benefits of treatment, and the consequences of failure to seek or delay treatment. Patient has read this document or had it read to him/her and understands the contents herein. The Patient has had the opportunity to ask questions of the Physician and has received answers to all of his or her questions.

By signing below, Patient (1) consents to the care, treatment, and services described in this document and orally by the Physician, (2) consents to the creation of images to record his or her wounds; and (3) consents to the transfer of health information protected by HIPAA between Physician, Hospital and WCC.

Signature of Patient/Responsible Person: _____ Date: _____ Time: _____

Relationship to Patient: _____

Witness: _____ Date: _____ Time: _____

Signature of Interpreter: _____ Date: _____ Time: _____
(If services utilized)

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

Legal Guardian or Legal Representative: _____ Date: _____ Time: _____

Print name: _____

The undersigned Physician has explained to the Patient (or his/her legal representative), in layman's terms, the nature of the treatment, reasonable alternative, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment of procedure(s).

Signature of Physician: _____ Date: _____ Time: _____