PHYSICIAN STATEMENT:

THIS FORM MUST BE FILLED BY AN MD, ND, DO, DC OR ANY OTHER PRACTITIONER WHO IS LICENSED TO RECOMMEND HYPERBARIC OXYGEN THERAPY (HBOT) AND BROUGHT WITH YOU TO YOUR APPOINTMENT OR EMAILED TO: TAOSHBOT@ICLOUDCOM PRIOR YOUR APPOINTMENT.

Patient / Client Name: ________________________________ Date of Birth: _________

I am willing to confirm that Mr/Mrs/Ms _______________________________ is fit to be inside a Hyperbaric Chamber and approved for HBOT sessions, not to exceed a typical hyperbaric program consisting of 60-minute sessions at 1.3 ATA, one to two times daily (minimum of 4 hours apart), and consecutively for 5 days until a total of 40 hours is achieved.
Additional oxygen via an oxygen concentrator may be used by facial mask or cannula, but not to exceed 8 lpm or 4 lpm, respectively.

PLEASE CHECK HERE __________ IF THE FOLLOWING APPLIES TO YOUR PATIENT:
My patient/client wishes to use Mild-Hyperbaric Oxygen Therapy (MHBOT) for general health & wellness.

PLEASE CHECK HERE __________ IF THE FOLLOWING APPLIES TO YOUR PATIENT:
My patient has been diagnosed with ____. I recommend m-HBOT at 1.3 ATA for ______ number of sessions.

PLEASE CHECK HERE __________ IF THE FOLLOWING APPLIES TO YOUR PATIENT:
I do not recommend the use of Mild Hyperbaric Oxygen Therapy (MHBOT) for the reasons stated below:

____

Additional Comments:

____

Physician's Name: ____________________________________

Physician's Signature: ________________________________.

Physician's Phone: ___________________________________

Physician's Email: ___________________________________

LICENSE # / STAMP