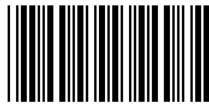
Hartford Hospital
A Hartford HealthCare Partner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Authorization for Hyperbaric Oxygen

Patient's Name: ___________________________________

I hereby authorize Dr.______________________________ to perform the following special

procedure/treatment: **Hyperbaric Oxygen**

I understand that residents and/or medical students may also be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified special procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed special procedure/treatment that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery/procedure/treatment: (i) the nature and purpose of the proposed procedure/treatment; (ii) the foreseeable risks and consequences of the proposed procedure/treatment, including the risk that the proposed procedure/treatment may not achieve the desired objective; (iii), the alternatives to the proposed surgery/procedure/treatment and the associated risks and benefits to such alternatives.

Specifically, in obtaining my informed consent to the special procedure/treatment, I have been informed of the following reasonably foreseeable risks:

- Barotrauma to ears and sinuses (ear and/or sinus pain, trouble clearing ears, ruptured eardrum)
- Oxygen toxicity (seizures, chest pain, cough, trouble breathing)
- Visual changes
- Gastrointestinal discomfort (gas)
- Increased risk of fire
- Pneumothorax (collapsed lung)
- Air embolism
- Death

__________Patient initial

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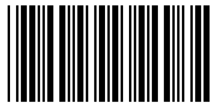
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I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed procedure/treatment.

I also authorize the Hospital and the above-named physician(s) to photograph, video and /or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

____ Signed: ____________________________________
MD Patient or legally authorized representative

Date:_____________Time:_________________ Date:___________Time:_______________

Interpreter responsible for explaining procedures and special treatment:

____
Interpreter

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [□] BECAUSE:

____

_______________________________________ Date:___________Time:_______________
MD
_______________________________________ Date:___________Time:_______________
Witness