BACK in line
FAMILY CHIROPRACTIC AND WELLNESS

Physician Hyperbaric Treatment Prescription

Patient Name:_____

DOB: _____/ _____/ _____

_____ PO2 _____ minutes

_____ # of Treatments

_____ # Air Breaks _____ minutes

M-F (5 X per week) or as schedule allows

Dx

Re-evaluation

Date: _____/ _____/ _____ Or Tx #: _____

Are you recommending: ☐ 100% O2 ☐ 95% O2

Refills Circle one NR 1 2 3 4

Notes:

_____

_____

Physicians Name: _____

Physician Signature: _____

NPI: _____ Date: _____/ _____/ _____

"Make Healthy Contagious"