The Chilterns Neuro Centre,

Oakwood Close,

Wendover,

Bucks, HP22 5LX

Date:

Dear Dr

|  |
| --- |
| **Reference: Oxygen Therapy at the Chilterns Neuro Centre** |

The following patient has indicated a wish to undertake a course of Oxygen Therapy at this Centre as part of their self management plan.

|  |  |
| --- | --- |
| **Title** |  |
| **Name** |  |
| **D.O.B.** |  |
| **Address** |  |

There are some recognised contra-indications to this treatment. Please can you complete the form attached detailing whether any of the contra-indications listed are applicable to your patient.

Please contact the Centre if you require further information.

I would be grateful if you would sign the enclosed forms and either return to the patient or return by post to the Centre at your earliest convenience.

Yours sincerely

**Jody Barber**

**Head of Integrated Clinical Services**

|  |
| --- |
| **OXYGEN THERAPY** |

To:

Clinical Administration,

The Chilterns Neuro Centre,

Oakwood Close,

Wendover,

Bucks, HP22 5LX

I acknowledge receipt of notification that my patient has registered for Oxygen Therapy at the Chilterns Neuro Centre.

|  |  |
| --- | --- |
| **Title** |  |
| **Name** |  |
| **D.O.B.** |  |
| **Address** |  |

**Please tick the relevant boxes below to indicate if any of the following contra-indications apply to the above-named patient:**

|  |  |  |
| --- | --- | --- |
| **CONTRA-INDICATIONS** | **YES** | **NO** |
| Past medical history of pneumothorax. |  |  |
| Chronic Obstructive Pulmonary Disease. |  |  |
| History of tuberculosis |  |  |
| Cancer. Current treatment or history of past Stage 3 or 4 cancer.  Any type of chemotherapy. |  |  |
| Epilepsy or past medical history of seizures. |  |  |
| Insulin controlled diabetes  (Type 1 or Type 2 diabetes). |  |  |
| Poorly controlled Type 2 diabetes. |  |  |
| Congenital spherocytosis. |  |  |
| Epidural pain pump or any other internally fitted device (including pacemaker) unless this has been pressure-tested by the manufacturer. |  |  |
| Claustrophobia. |  |  |
| Eustachian tube dysfunction, perilymph fistula or otosclerosis. |  |  |
| Pregnancy. |  |  |
| Current use of Bleomycin. |  |  |
| Current use of Cisplatin. |  |  |
| Current use of Doxorubicin. |  |  |
| Use of Disulfiram. |  |  |
| Current use of Sulfamylon /mafenide acetate. |  |  |
| Participating in a drug trial unless consent given by trial clinicians. |  |  |

|  |  |
| --- | --- |
| **Please complete** |  |
| I confirm that I know no reason why he/she should not access this therapy as part of their self-management plan (cross out as appropriate) | YES  NO |
| Print name: |  |
| Signature: |  |
| Date: |  |
| Address: |  |
| Telephone: |  |

**New 02 005**