Recompression Chamber Network
Initial Assessment Form*

_____
_____
Updates

*Please note that the information provided by the facility is not intended as exclusion criteria. The information is required for DAN to be able to assess preparedness levels, availability, the degree of patient life-support, and the ability to handle the severity of the conditions that a patient could present with, amongst other referral considerations.

Contact Information

_____ _____ _____
Name of Hyperbaric Facility *Address of Hyperbaric Facility* *Date*

_____ _____ _____ _____
City *State/Province/Other* *Postal Code* *Country*

_____ _____ _____
Telephone (Office hours) *Telephone (24/7 Emergency)* *E-mail address*

Chamber Facility Information

Hospital Based: ☐ Yes ☐ No **Name of Hospital:** _____ **Chamber manufacturer:**_____

Number of chambers _____ **Chamber Age(s)**: _____ **Facility years in operation** _____

Chamber Model Type: ☐ Monoplace ☐ Multiplace ☐ Both **In-Chamber Life Support:** ☐ Yes ☐ No

Availability: ☐ 24/7/365 ☐ Business hours ☐ On-call only

Medical Doctor: **Staff** ☐ On-site, full time ☐ On-site, on call ☐ On-call only ☐ No Medical Doctor

Training: ☐ Certified (CHT, DMT) ☐ Formal Off-Site ☐ On-the-job ☐ Training not recorded

Patients per year: ☐ 5 patients or less ☐ 6 - 50 patients ☐ 51 or more patients

Chamber Vessel Certification: ☐ Documented Chamber Vessel ☐ Undocumented, re-certified ☐ Undocumented, condition unknown.

View Ports: ☐ In-date, certified ☐ Out-of-date, certified ☐ No manufacturer certification

Treatments offered: ☐ TT6 ☐ TT6, full extensions ☐ Comex 30 ☐ Other _____

Treatment Gases: ☐ Oxygen ☐ Nitrox ☐ Heliox

Gas Supplies: ☐ Air WITH redundant systems ☐ Air WITHOUT redundant systems ☐ Oxygen WITH redundant systems ☐ Oxygen WITHOUT redundant systems

Fire Deluge: ☐ Handheld extinguisher ☐ Overhead Deluge ☐ Both ☐ None ☐ N/A, monoplace chamber

Internal Electrical Devices: ☐ Comms only ☐ Comms and lights ☐ Additional devices ☐ None

Fire alarms in room: ☐ Yes ☐ No **Room fire extinguisher/deluge:** ☐ Yes ☐ No

Clear form

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Funding:
☐ Sustainable as part of a larger facility
☐ Sustainable based on diving treatments
☐ Presently unsustainable
☐ Subsidized: local dive community, tourism, other
☐ Unsure based on no operating history

Treatment lock analyzers: ☐ O_2 ☐ CO_2 ☐ None **Back-up Power:** ☐ Yes ☐ No

Maintenance Program: ☐ Manufacturer, scheduled ☐ In-house, scheduled ☐ Manufacturer, as required ☐ In-house, as required ☐ Contractor, as required ☐ None

Compressed Air Quality Analyzed: ☐ Yes, regularly ☐ Yes, not regularly ☐ No ☐ Certified Medical Air

Emergency Procedures: ☐ Yes, drilled ☐ Documented only ☐ No **Facility safety manual:** ☐ Yes ☐ No

Patient liability Release Forms: ☐ Yes ☐ No **Dedicated Chamber Clothing:** ☐ Yes ☐ No

Persons of Contact

Medical Director:

_____ _____ _____
Name *Telephone* *Email*

Other contact persons:

_____ _____ _____
Name ☐ Doctor ☐ Nurse ☐ Tech ☐ Admin *Telephone* *Email*

_____ _____ _____
Name ☐ Doctor ☐ Nurse ☐ Tech ☐ Admin *Telephone* *Email*

_____ _____ _____
Name ☐ Doctor ☐ Nurse ☐ Tech ☐ Admin *Telephone* *Email*

Other Information

Languages spoken: _____

Hyperbaric Chamber Website ☐ Yes ☐ No **Website address** _____ **Fax:** _____

Other Info/Comments:

SUBMIT TO DAN

The information provided by the submission of this form is not intended as exclusion criteria.
It is needed to assess chamber capability, availability and safety, amongst other referral considerations.

Clear form