Recompression Chamber Network
Initial Assessment Form*

*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 (if applicable)** _____

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

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

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View Ports: ☐ In-date, certified ☐ Out-of-date, certified ☐ No manufacturer certification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

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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:

_____ _____ _____
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 completion and submission of this form does not imply any form of recognition, endorsement, or acceptance as a DAN referral facility. Recognition as a DAN referral center requires the diving medical officer, or the facility's medical director, to apply to become a DAN in-network service provider.