

**DAN**

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View Ports:	In-date, certified	Out-of-date, certified	No manufacturer certification		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 Subsidized: local dive community, tourism, other
 Sustainable based on diving treatments Unsure based on no operating history
 Presently unsustainable

Treatment lock analyzers: O₂ CO₂ None **Back-up Power:** Yes No

Maintenance Program: Manufacturer, scheduled Manufacturer, as required Contractor, as required
 In-house, scheduled In-house, 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:

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.