CUMMING
HYPERBARIC PHYSICIANS
OF GEORGIA
LymphEdema

Your Partners In Healing

1505 Northside Boulevard, Suite 1300,
Cumming, GA 30041

P: 678-388-9511 ♦ F: 678-388-9544

www.hbomdga.com

Frank Aviles Jr,
PT, CWS, FACCWS, CLT-LANA, ALM,
AWCC, MAPWCA

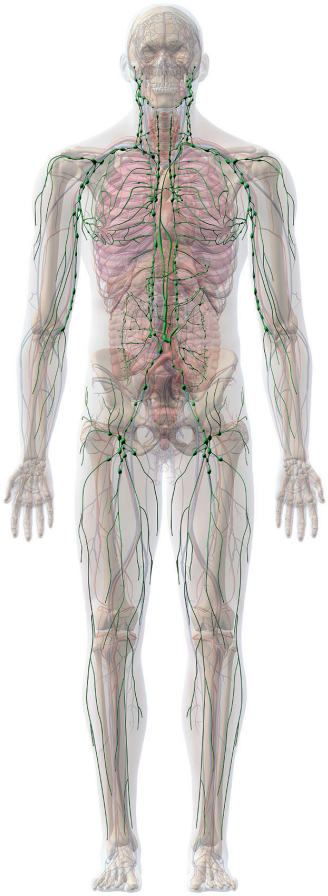
**Director of Lymphatic &
Wound Healing Services**

PATIENT GUIDE TO LYMPHATIC TREATMENT

NOTE:

Patient hereby voluntarily consents to Lymphatic and wound care treatment by physician, facility and their respective employees, agents, representatives, (hereinafter sometimes collectively referred to as the "practice"). The patient has the right to give or refuse consent to any proposed procedure or treatment at any time before its performance.

This form is to be signed by all Lymphatic and wound care patients or their legal representatives. If patient is going to receive hyperbaric oxygen therapy, the patient must also execute the "**Patient Guide to Hyperbaric Oxygen Therapy**" consent form.



What is Lymphatic Dysfunction?

immune system; one function is removing a particular type of fluid called lymph. When the lymphatic system works poorly, it creates tissue swelling that may resolve slower than normal.

A poorly & overworked functioning lymphatic system may become damaged over time, progressing to Lymphedema.

What is Lymphedema?

Lymphedema is a progressive disease that can be managed. The lymphatic system is responsible for transporting and removing lymph fluid from your cells and tissues through specific lymph vessels and lymph nodes. Once this system is damaged, if not addressed adequately, the area with this fluid accumulation can increase in size, develop skin changes, and decrease quality of life.

What causes Lymphedema?

Lymphedema can occur from a malformation of the lymphatic system or an injury such as surgery, radiation, cancer treatment, long-standing venous leg problems, lipedema, or trauma. As this disease progresses, skin changes such as skin growth, hardened skin (fibrosis), size of the limb may increase, recurrent skin infections, and poor healing ulcers may develop.

General Description of Lymphatic Treatment:

Lymphatic treatment may vary based on the condition, presentation, and severity of the involved area(s). Whether treating lymphatic dysfunction or Lymphedema, treatment may include, but not be limited to an assessment of the involved area, manual lymphatic drainage, skin care, compression including bandages or garments, exercises, education, and/or adjunctive devices. The gold standard for treating Lymphedema is Complete Decongestive Therapy, including the treatment components described above.

Benefits of Lymphatic Treatment:

The benefits of lymphatic treatment may include decreasing swelling, decreasing pain, rerouting lymphatic fluid from the swollen area to a healthy area, promoting lymph fluid reabsorption, improving venous return, optimizing the muscle pump effect, softening fibrotic tissue (hardened tissue from prolonged untreated swelling), improving joint range of motion & mobility while educating each patient on how to manage this condition.

Risks/Side Effects of Lymphatic Treatment:

Lymphatic treatment is usually safe with minimal risks. Manual lymphatic drainage, a component of Complete Decongestive Therapy, is a soft and gentle type of light massage provided typically by a therapist. It is desired to seek the help of a therapist designated as a CLT (Certified Lymphedema Therapist). If your therapist produces pain during this component, then higher than normal unwanted pressure is being applied.

The assessment will also determine certain conditions that the treatment will either be modified or not performed, such as untreated heart conditions, infections, blood clots, liver problems, blood clots, and poor arterial circulation.

ACHIEVING GOALS:

This therapy's success depends on compliance, consistency, and adherence to the program. The program includes being active in the care provided, applying appropriate bandages or garments, exercising as indicated, following good skin care practices, following a list of ***do and do not,*** learning self-manual drainage techniques, and if needed finding needed support to accomplish the above.

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LYMPHATIC TREATMENT

Patient Last: _____ First: _____ MI: ____ Date of Birth: _____

Physician: ☐ Joni K. Hodgson, DO ☐ David Schwegman, MD ☐ Helen Gelly, MD ☐ Daniel Beless, MD ☐ Marina Wilder, MD
☐ Timothy Hutton, MD ☐ Laura Holmes, MD ☐ _____

Therapist: ☐ Frank Aviles, Jr., PT,

The patient hereby acknowledges that he or she has read or had this document read to them and agrees to its contents **(PATIENT GUIDE TO LYMPHATIC WOUND CARE TREATMENT)**. Patient agrees that his or her medical condition has been explained to him or her by the physician or therapist. Patient agrees that the risks, benefits and alternatives regarding all care, treatment, and services that patient will undergo have been discussed with patient by physician or the therapist. Patient understands the nature of his or her medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. The patient has had the opportunity to ask questions of the physician and has received appropriate answers to all of his or her questions.

By signing below, I agree that: (1) My signature below constitutes acknowledgment that I have read and agree to the attached document, and that a physician/therapist has satisfactorily explained the care I will be receiving to me, I have received "**PATIENT GUIDE TO LYMPHATIC WOUND CARE TREATMENT**", and that I have all the information that I desire. (2) I grant permission to take medical photographs of my condition and hereby authorize the publishing or reproduction of such photographs for correspondence with my referring physician and for teaching/educational/publishing purposes. I understand that I will not be identified by name and that my anonymity will be preserved in any presentation or publication. (3) I consent to the transfer of health information protected by HIPAA for purposes related to treatment, payment, and health care operations. (4) Furthermore, I grant permission to take a photograph of myself for the purpose of patient identification. This photograph shall remain a permanent part of my patient record.

Patient understands that this *Consent Form* will be valid and remain in effect from the date of signature, as long as the patient receives care, treatment, and services at the practice. After a patient is discharged, and the patient returns for care, treatment, or service, a new consent form will have to be signed.

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative *Date*
(Guardian or authorized representative must attach documentation of such status.)

_____ _____
Printed Name of Authorized Representative *Relationship/Capacity to Patient*

_____ _____
Witness Signature *Date*

_____
Printed Name of Witness

The undersigned physician or therapist has explained to the patient (or his or her legal representative), in layman's terms, the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment or procedure(s).

_____ _____
Signature of Physician/Therapist *Date*

ORIGINAL SIGNATURE STAYS IN PATIENTS CHART

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