sub zero cryotherapy

AUTHORIZATION FOR WHOLE BODY CRYOTHERAPY

Patient's Name: _____ Date of Birth: _____

This request and authorization applies to:

DEFINITION: Whole Body Cryotherapy- is the process of the skin being exposed to sub zero temperatures causing rapid shunting of the circulation from the periphery to the core for a limited time (i.e. 2-3 minutes) at which time the client is removed from the exposure to allow for rapid vasodialation and therefore detoxification from the subcutaneous layers.

HOW: The temperature in the body's core must be constant and equal to -98.6°F. So upon receipt of signals from the skin's cold sensors of the sub zero temperatures in the cryosauna, the brain center has a clear warning that maintaining the necessary core body temperature will be impossible if blood circulation in the outer layers of the skin is allowed to continue. Therefore, all survival resources are mobilized, and blood is sent into the body's core to begin circulating in an "internal cycle" to protect the vital organs. An immediate effect includes an increase in the arterial blood pressure by about 10 points. For example, if the systolic pressure (upper number) was 130 points (or millimeter of mercury) before the treatment, it may reach 135-140 afterwards for a short time.

CONTRAINDICATIONS:
Pregnancy, severe Hypertension (BP> 180/100), acute or recent myocardial infarction, unstable angina pectoris, arrhythmia, symptomatic cardiovascular disease, cardiac pacemaker, peripheral arterial occlusive disease, venous thrombosis, acute or recent cerebrovascular accident, uncontrolled seizures, Raynaud's Syndrome, fever, tumor disease, symptomatic lung disorders, bleeding disorders, severe anemia, infection, cold allergy, acute kidney and urinary tract diseases.

☐ Yes ☐ No I authorize my patient to participate in session of whole body cryotherapy. I understand that the person(s) listed above could present with an increased systolic blood pressure (normally 10 points) and is stable enough to tolerate the increase without adverse reaction.

Physician Signature: _____ Date Signed: _____

THIS AUTHORIZATION REMAINS IN EFFECT UNITL IF/WHEN THE CLIENT SUSTAINS ANOTHER QUALIFYING EVENT.