CLEAR FORM

Medigas
A Linde company

RESPIRATORY REFERRAL / REQUISITION OF SERVICES

During normal business hours, fax to **1-855-233-1160.** For after hours service please call 1-866-446-6302

PATIENT INFORMATION (please print)

Last Name	First Name	Sex ☐M ☐F
Address	City / Prov. / Postal Code	
Primary Tel.	Health Card #	Date of Birth mm / dd / yyyy
Diagnosis		Palliative ☐YES ☐NO

PHYSICIAN/NURSE PRACTITIONER: PLEASE COMPLETE APPLICABLE PRESCRIPTION(S)

RESPIRATORY

☐ Respiratory Assessment: may include oximetry testing on room air at rest, on exertion and/or nocturnal

☐ **Home Oxygen Therapy**
Maintain SpO_2 > 89% or between _____ - _____ %
OR
Rest _____ LPM _____ hours/day
Exertion _____ LPM _____ hours/day
Nocturnal _____ LPM _____ hours/day

☐ **COPD Management**

☐ **Other Respiratory Therapy** *(specify)*

_____

For provincial funding in AB, ON & SK only

Qualifying ABG Date (mm/dd/yyyy) _____

Results: pH _____ PO_2 _____ PCO_2 _____ SaO_2 _____%

☐ ABG could not be taken due to medical risk

Reason (specify) _____

SLEEP

☐ Level III (HSAT) Home Sleep Screening

☐ Level III Home Sleep Screening (HSAT)*: with a positive outcome to sleep screening, as determined by interpreting physician, initiate auto-titration CPAP trial using the following limits:

4 Min. Pressure 20 Max. Pressure
OR
_____ Min. Pressure _____ Max. Pressure

***Level I testing is required in ON & SK for provincial government funding of PAP therapy**

(Following Auto-titration CPAP Trial)

☐ **Auto CPAP Therapy**

Min Pressure _____ Max Pressure _____
Auto CPAP may be changed to standard CPAP based on auto-titration average pressure for 90% of titration time.

☐ **CPAP Therapy**

_____ cm H_2O _____ Ramp (minutes)

COMMENTS/SPECIAL INSTRUCTIONS

Physician/Nurse Practitioner Name _____ **Tel:** _____ **Email:** _____

Physician/Nurse Practitioner Signature _____ **Date** mm / dd / yyyy

A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER