

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**

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PATIENT INFORMATION

| | | |
|---------------|----------------------------|--|
| Last Name | | Sex |
| First Name | | <input type="checkbox"/> M <input type="checkbox"/> F |
| Address | | |
| City | Province | Postal Code |
| Primary Tel. | Date of Birth (mm/dd/yyyy) | Palliative |
| Health Card # | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diagnosis | | |

RESPIRATORY

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

Home Oxygen Therapy

Maintain SpO₂ >89% or between _____ - _____ % OR

Rest _____ LPM _____ hours/day

Exertion _____ LPM _____ hours/day

Nocturnal _____ LPM _____ hours/day

COPD Management

Other Respiratory Therapy (*specify*)

(*specify*) _____

For provincial funding in AB, ON & SK only

Qualifying ABG Date (mm/dd/yyyy) _____

Results: pH _____ PO₂ _____ PCO₂ _____ SaO₂ _____ %

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 1 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 H₂O _____ Ramp (minutes)

COMMENTS / SPECIAL INSTRUCTIONS

Physician / Nurse Practitioner Name:

Telephone

Email

License No.

Physician / Nurse Practitioner Signature:

Date (mm/dd/yyyy)

A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER