InspiAIR®
Breathe. Sleep.

PHONE: 1.866.626.8697 24 | 7 | 365
FAX: 1.888.895.7180 M–F | 9–6pm
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REFERRAL FORM FOR DIAGNOSTICS, OXYGEN, & PAP THERAPY

PATIENT INFORMATION

Patient's Name: _____ (M/F) Address: _____ (NUMBER STREET APARTMENT)

Date of Birth: _____ (YYYY MM DD) _____ (CITY PROVINCE POSTAL CODE)

Health Card #: _____ (OHIP # VERSION CODE) Telephone#: _____

Next of Kin: _____ Telephone#: _____

DIAGNOSIS

☐ Palliative ☐ Acute O_2 Need ☐ Chronic O_2 Need

Dx: _____

_____

ROOM AIR ABGs (CHRONIC)

Date: _____ (YYYY MM DD) pH _____

$PaCO_2$ _____ PaO2 _____

SaO_2 _____ HCO_3 _____

OXYGEN THERAPY

Hours of use per day: _____

Nasal Cannula: _____ (LPM)
(REST EXERTION SLEEP)

Comments: _____

OXIMETRY TESTING

Testing on room air unless specified otherwise: _____

☐ Daytime Resting ☐ Daytime Exertion ☐ Nocturnal (Sleep)

Comments: _____

OXYGEN FUNDING PROGRAM

☐ Long Term Resting Hypoxemia

☐ Long Term Exertional Hypoxemia ☐ IEA Included

☐ Palliative Care (90 days)

☐ Short Term Hypoxemia (60 days)

CPAP/PAP THERAPY

Pressure: _____ cm H_2O Comments: _____

PRESCRIBER SIGN OFF

X _____ _____ _____ ☐ Physician ☐ Nurse Practitioner
Prescriber Signature | Prescriber Name | Billing #

If completed by other: _____ Date: _____
(NAME DESIGNATION TELEPHONE#) (YYYY MM DD)

PrimaryCare Provider Name: _____

Hospital/Clinic Name: _____

Discover the InspiAIR Difference™