InspiAIR® LOCALLY OWNED
Breathe. Sleep.

# REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

## 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 #: _____

Emergency Contact: _____ Telephone #: _____

## DIAGNOSIS

Primary Dx: _____

Secondary Dx: _____

❒ Palliative ❒ Chronic $O_2$ Need ❒ Acute $O_2$ Need

## ROOM AIR ABGs (CHRONIC)

Date: _____ (YYYY MM DD) pH _____

$PaCO_2$ _____ $PaO_2$ _____

$SaO_2$ _____ $HCO_3$ _____

❒ Perform ABG ❒ Could not be taken due to medical reason

## OXYGEN THERAPY

Rest LPM: _____ Hrs./Day: _____

Exertion: _____ Hrs./Day: _____

Nocturnal: _____ Hrs./Day: _____

## OXIMETRY TESTING

Testing on room air unless specified otherwise: _____

❒ Daytime Resting ❒ Daytime Exertion ❒ Nocturnal

Comments: _____

## PAP/AUTO/BILEVEL THERAPY

CPAP Setting: _____ cm $H_20$ Auto Setting: _____ cm $H_20$

Bi Level Setting: _____ cm $H_20$ ❒ Sleep Study Included

## PRESCRIBER SIGN OFF

❒ Physician
❒ Nurse Practitioner

_____ (Prescriber Name) X _____ (Prescriber Signature) _____ (Billing #)

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

Primary Care Provider Name: _____ Hospital/Clinic Name: _____

**PLEASE FAX COMPLETED FORM TO 613-933-2060**
**During normal business hours**
**For after hours service please call 613-938-2626**