NORTHERN RESPIRATORY
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 705-942-1284
During normal business hours
For after hours service please call 705-253-9333

625 Trunk Rd., Unit #14 SAULT STE. MARIE **ON P6A 3T1** | northernrespiratory@gmail.com

v. December 2020