NORTHERN RESPIRATORY
Breathe. Sleep.

705 Red River Rd., Unit #2
Thunder Bay ON P7B 1J3
Office:807-767-1247
email: tbay@northernrespiratory.ca

REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

Patient's Name: ______________________ M/F/X

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 ______________________

❒ Could not be taken due to medical reason

OXYGEN THERAPY

Rest LPM: ____________ Hrs./Day: ____________

Exertion: ____________ Hrs./Day: ____________

Nocturnal: ____________ Hrs./Day: ____________

TESTING

Testing on room air unless specified otherwise: ____________

❒ Daytime Resting ❒ Daytime Exertion ❒ Nocturnal

Comments: ______________________

PAP/AUTO/BILEVEL THERAPY

CPAP Setting: ____________ cm $H_2 0$ Auto Setting: ____________ cm $H_2 0$

Bi Level Setting: ____________ cm $H_2 0$ ❒ Sleep Study Included

PRESCRIBER SIGN OFF

❒ Physician
❒ Nurse Practitioner

______________________ X ______________________ ______________________
Prescriber Name Prescriber Signature OHIP Billing #

If completed by other: ______________________
NAME DESIGNATION TELEPHONE#

Date: ______________________
YYYY MM DD

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

During regular business hours M-F I 9-5pm

PLEASE FAX COMPLETED FORM TO 807-577-8675

For after hours service please call 807-620-1665

northernrespiratory.ca

v. December 2020