NORTHERN RESPIRATORY
Breathe. Sleep.

60 Champlain St., Unit #102
North Bay ON P1B 7M4
Office: 705-475-1881
email: info@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: _____

RESPIRATORY ASSESSMENT / 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

_____ 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 Mon-Thur 9-5pm, Fri 9-4pm
PLEASE FAX COMPLETED FORM TO 705-497-3753
For after hours service please call 705-499-5530

northernrespiratory.ca