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

REMOTE CARE MONITORING

❒ RCM

Device Pickup Location: _____

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 613-961-7557
During normal business hours
For after hours service please call 613-961-7070