InspiAIR® LOCALLY OWNED
Breathe. Sleep.

PHONE: 1.866.626.8697
FAX: 1.888.895.7180
EMAIL: referrals@inspiair.ca

REFERRAL FORM FOR DIAGNOSTICS, OXYGEN, & PAP THERAPY

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#: _____

Next of Kin: _____

Telephone#: _____

DIAGNOSIS

☐ Palliative ☐ Acute O_2 Need ☐ Chronic O_2 Need

Dx: _____

_____

ROOM AIR ABGs (CHRONIC)

Date: _____ (YYYY / MM / DD)

pH _____

$PaCO_2$ _____

PaO2 _____

SaO_2 _____

HCO_3 _____

OXYGEN THERAPY

Hours of use per day: _____

Flow Rate: _____ (LPM) (REST / EXERTION / SLEEP)

Comments: _____

OXIMETRY TESTING

Testing on room air unless specified otherwise: _____

☐ Daytime Resting ☐ Daytime Exertion ☐ Nocturnal (Sleep)

Comments: _____

OXYGEN FUNDING PROGRAM

☐ Long Term Resting Hypoxemia ☐ COVID-19

☐ Long Term Exertional Hypoxemia ☐ IEA Included

☐ Palliative Care (90 days)

☐ Short Term Hypoxemia (60 days)

CPAP/PAP THERAPY

Pressure: _____ cm H_2O Comments: _____

PRESCRIBER SIGN OFF

X _____ (Prescriber Signature) _____ (Prescriber Name) _____ (Billing #) ☐ Physician ☐ Nurse Practitioner

Prescriber Email: _____ (for electronic signature) Date: _____ (YYYY / MM / DD)

PrimaryCare Provider Name: _____ Floor/Ward: _____

Hospital/Clinic Name: _____ Room Number: _____

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