

REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

Patient's Name: _____ Address: _____
M/F NUMBER STREET APARTMENT

Date of Birth: _____
YYYY MM DD CITY PROVINCE POSTAL CODE

Health Card #: _____ Telephone #: _____
OHIP # VERSION CODE

Emergency Contact: _____ Telephone #: _____

DIAGNOSIS

Primary Dx: _____

Secondary Dx: _____

Palliative Chronic O₂ Need Acute O₂ Need

ROOM AIR ABGs (CHRONIC)

Date: _____ pH _____
YYYY MM DD

PaCO₂ _____ PaO₂ _____

SaO₂ _____ HCO₃ _____

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 H₂O Auto Setting: _____ cm H₂O

Bi Level Setting: _____ cm H₂O Sleep Study Included

PRESCRIBER SIGN OFF

_____ X _____
Prescriber Name Prescriber Signature Billing #

Physician Nurse Practitioner

If completed by other: _____ Date: _____
NAME DESIGNATION TELEPHONE# YYYY MM DD

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

PLEASE FAX COMPLETED FORM TO 705-419-2989
During normal business hours
For after hours service please call 705-419-2922