InspiAIR® LOCALLY OWNED
Breathe. Sleep.

Phone: 1.866.626.8697
Fax: 1-888-895-7180
Email: referrals@inspiair.ca

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

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

PRECAUTIONS (if known)

❒ Current Smoker
❒ Pets
❒ Infestation Issues
❒ Other _____

PRESCRIBER SIGN OFF

❒ Physician
❒ Nurse Practitioner

_____ X _____ _____

Prescriber Name Prescriber Signature Billing #

If completed by other: _____ Date: _____

NAME DESIGNATION TELEPHONE# YYYY MM DD

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

PLEASE FAX COMPLETED FORM TO 1-888-895-7180
During normal business hours
For after hours service please call 1-866-626-8697

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