InspiAIR® LOCALLY OWNED
Breathe. Sleep.

REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

Patient's Name: _____ Address: _____
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 O_2 Need ☐ Acute O_2 Need

ROOM AIR ABGs (CHRONIC)

Date: _____ pH _____
YYYY MM DD

$PaCO_2$ _____ PaO_2 _____

SaO_2 _____ HCO_3 _____

☐ Perform ABG ☐ Could not be taken due to medical reason

OXYGEN THERAPY

Rest LPM: _____ Hrs./Day: _____

Exertion LPM: _____ Hrs./Day: _____

Nocturnal LPM: _____ Hrs./Day: _____

OXIMETRY TESTING

Testing on room air unless specified otherwise: _____

☐ Daytime Resting ☐ Daytime Exertion ☐ Nocturnal

Comments: _____

CPAP/AUTO/BILEVEL THERAPY

CPAP Setting: _____ cmH_2O Auto Setting: _____ cmH_2O

Bilevel Setting: _____ cmH_2O ☐ Sleep Study Included

PRECAUTIONS (if known)

☐ Current Smoker

☐ PPE Precautions

☐ Other _____

NOTES/COMMENTS

_____

_____

PRESCRIBER SIGN OFF

_____ X _____ _____ ☐ Physician ☐ Nurse Practitioner
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 613-933-2060
FOR AFTER HOURS SERVICE PLEASE CALL 613-938-2626