

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 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 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: _____ cmH₂O Auto Setting: _____ cmH₂O

Bilevel Setting: _____ cmH₂O ☐ Sleep Study Included

PRECAUTIONS (if known)

☐ Current Smoker

☐ PPE Precautions

☐ Other _____

NOTES/COMMENTS

PRESCRIBER SIGN OFF

Prescriber Name

X _____
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 705-702-1084
FOR AFTER HOURS SERVICE PLEASE CALL 705-743-2670