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 _____ _____
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 705-741-4281
FOR AFTER HOURS SERVICE PLEASE CALL 705-743-2670