

REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

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

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

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

Emergency Contact: _____ Telephone #: _____

DIAGNOSIS

Primary Dx: _____

Secondary Dx: _____

☐ Palliative ☐ Chronic 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

PRECAUTIONS (if known)

☐ Current Smoker

☐ Pets

☐ Infestation Issues

☐ Other _____

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 226-314-1215
During normal business hours
For after hours service please call 226-314-4460