

REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

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

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

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

Emergency Contact: _____ Telephone #: _____

DIAGNOSIS ROOM AIR ABGs (CHRONIC)

Primary Dx: _____ Date: _____ pH _____
YYYY MM DD

Secondary Dx: _____ PaCO₂ _____ PaO₂ _____

SaO₂ _____ HCO₃ _____

Palliative Chronic O₂ Need Acute O₂ Need

Could not be taken due to medical reason

OXYGEN THERAPY TESTING

Rest LPM: _____ Hrs./Day: _____ Testing on room air unless specified otherwise: _____

Exertion: _____ Hrs./Day: _____ Daytime Resting Daytime Exertion Nocturnal

Nocturnal: _____ Hrs./Day: _____ Comments: _____

PAP/AUTO/BILEVEL THERAPY

CPAP Setting: _____ cm H₂O Auto Setting: _____ cm H₂O

Bi Level Setting: _____ cm H₂O Sleep Study Included

PRESCRIBER SIGN OFF

Prescriber Name X Prescriber Signature OHIP Billing #

Physician
 Nurse Practitioner

If completed by other: _____ Date: _____
NAME DESIGNATION TELEPHONE# YYYY MM DD

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

During regular business hours Mon-Thur 9-5pm, Fri 9-4pm
PLEASE FAX COMPLETED FORM TO 705-467-3753
For after hours service please call 705-499-5530
northernrespiratory.ca