NORTHERN RESPIRATORY
Breathe. Sleep.

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REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

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

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

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

Emergency Contact: _____ Telephone #: _____

DIAGNOSIS

Primary Dx: _____

Secondary Dx: _____

☐ Palliative ☐ Chronic O_2 Need ☐ Acute O_2 Need

ROOM AIR ABGs (CHRONIC)

Date: _____ (YYYY MM DD) pH _____

$PaCO_2$ _____ PaO_2 _____

SaO_2 _____ HCO_3 _____

☐ Could not be taken due to medical reason

OXYGEN THERAPY

Rest LPM: _____ Hrs./Day: _____

Exertion: _____ Hrs./Day: _____

Nocturnal: _____ Hrs./Day: _____

TESTING

Testing on room air unless specified otherwise: _____

☐ Daytime Resting ☐ Daytime Exertion ☐ Nocturnal

Comments: _____

PAP/AUTO/BILEVEL THERAPY

CPAP Setting: _____ cm H_20 Auto Setting: _____ cm H_20

Bi Level Setting: _____ cm H_20 ☐ Sleep Study Included Comments: _____

PRESCRIBER SIGN OFF

☐ Physician
☐ Nurse Practitioner

_____ (Prescriber Name) X _____ (Prescriber Signature) _____ (OHIP Billing #)

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

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

During regular business hours M-F 8:30-4:30pm

PLEASE FAX COMPLETED FORM TO 807-470-1470

For after hours service please call 807-464-2309

www.northernrespiratory.ca

v. December 2020