InspiAIR® LOCALLY OWNED
Breathe. Sleep.

197 Third Street, Suite 2
Cobourg ON K9A 3L5
Tel: 289-251-4010
Fax: 1-905-556-2008
cobourg@inspiair.ca

REFERRAL FORM FOR OXYGEN, PAP THERAPY AND DIAGNOSTICS

PATIENT INFORMATION

Patient's Name: _____ (M/F)

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 ❒ Covid 19

ROOM AIR ABGs (CHRONIC)

Date: _____ (YYYY / MM / DD)

pH _____

$PaCO_2$ _____

PaO_2 _____

SaO_2 _____

HCO_3 _____

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 H_20

Auto Setting: _____ cm H_20

Bi Level Setting: _____ cm H_20

❒ Sleep Study Included

PRESCRIBER SIGN OFF

❒ Physician

❒ Nurse Practitioner

_____ X _____

Prescriber Name / Prescriber Signature

_____ Prescriber Email

_____ Billing #

If completed by other: _____ (NAME / DESIGNATION / TELEPHONE#)

Date: _____ (YYYY / MM / DD)

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

PLEASE FAX COMPLETED FORM TO 1-905-556-2008 during normal business hours.
For after hours service please call 289-251-4010

Discover the InspiAIR Difference™