InspiAIR® LOCALLY OWNED
Breathe. Sleep.

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Whitby ON L1N 4H6
Tel: 289-509-0639
Fax: 1-905-556-2008
whitby@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

_____ (Prescriber Name) X _____ (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 289-509-0639

Discover the InspiAIR Difference™