InspiAIR® LOCALLY OWNED
Breathe. Sleep.

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 ❒ Acute O_2 Need

ROOM AIR ABGs (CHRONIC)

Date: _____ (YYYY MM DD) pH _____

$PaCO_2$ _____ PaO_2 _____

SaO_2 _____ HCO_3 _____

❒ 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 H_20 Auto Setting: _____ cm H_20

Bi Level Setting: _____ cm H_20 ❒ Sleep Study Included

PRECAUTIONS (if known)

❒ Current Smoker
❒ Pets
❒ Infestation Issues
❒ Other _____

PRESCRIBER SIGN OFF

❒ Physician
❒ Nurse Practitioner

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

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

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

PLEASE FAX COMPLETED FORM TO 1-888-895-7180
During normal business hours
For after hours service please call 416-495-0775