NORTHERN RESPIRATORY
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: _____

OXYGEN THERAPY

❒ Home O_2 Assessment-Oximetry
- ❒ Rest ❒ Exertion ❒ Nocturnal

❒ Home O_2 Set up
- ❒ Palliative ❒ Chronic
- ❒ Keep SpO_2 88-92 %
- ❒ Keep SpO_2 >90%
- ❒ _____ rest _____ exertion _____ sleep

ABG Results (if available)

Date: _____ (YYYY / MM / DD)

pH _____

PaO_2 _____

$PaCO_2$ _____

❒ Waive ABG due to medical risk

Reason _____

SLEEP

❒ Level 3/4 Sleep Testing (in home)

❒ CPAP _____ cmH_2O ❒ APAP _____ cmH_2O

❒ Re-Assess CPAP/APAP Compliance

EQUIPMENT Rx

❒ Oximeter ❒ Nebulizer

❒ PEP Device ❒ Space Chamber for MDI use

OTHER

❒ Precaution: _____

❒ Comment: _____

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 705-419-2989 (During normal business hours)
For after hours service please call 705-419-2922

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v. December 2020