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

❒ Initiate Home O_2
- ❒ 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 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

_____ Prescriber Name

X _____ Prescriber Signature

_____ Billing #

❒ Physician

❒ Nurse Practitioner

If completed by other: _____ NAME DESIGNATION TELEPHONE#

Date: _____ YYYY MM DD

Primary Care Provider Name: _____

Hospital/Clinic Name: _____

PLEASE FAX COMPLETED FORM TO 705-942-1284

For after hours service please call 705-253-9333

625 Trunk Rd, Unit 14, Sault Ste. Marie, ON P6A 3T1 | northernssm@northernrespiratory.ca