

REFERRAL FORM FOR DIAGNOSTICS, OXYGEN, & PAP THERAPY

PATIENT INFORMATION

Patient's Name: _____ Address: _____
M/F NUMBER STREET APARTMENT

Date of Birth: _____
YYYY MM DD CITY PROVINCE POSTAL CODE

Health Card #: _____ Telephone#: _____
OHIP # VERSION CODE

Next of Kin: _____ Telephone#: _____

DIAGNOSIS

☐ Palliative ☐ Acute O₂ Need ☐ Chronic O₂ Need

Dx: _____

ROOM AIR ABGs (CHRONIC)

Date: _____ pH _____
YYYY MM DD

PaCO₂ _____ PaO₂ _____

SaO₂ _____ HCO₃ _____

OXYGEN THERAPY

Hours of use per day: _____

Flow Rate: _____ (LPM)
REST EXERTION SLEEP

Comments: _____

OXIMETRY TESTING

Testing on room air unless specified otherwise: _____

☐ Daytime Resting ☐ Daytime Exertion ☐ Nocturnal (Sleep)

Comments: _____

OXYGEN FUNDING PROGRAM

☐ Long Term Resting Hypoxemia

☐ Long Term Exertional Hypoxemia ☐ IEA Included

☐ Palliative Care (90 days)

☐ Short Term Hypoxemia (60 days)

CPAP/PAP THERAPY

Pressure: _____ cm H₂O Comments: _____

PRESCRIBER SIGN OFF

X _____
 Prescriber Signature Prescriber Name Billing # ☐ Physician ☐ Nurse Practitioner

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

Primary Care Provider Name: _____ Floor/Ward: _____

Hospital/Clinic Name: _____ Room Number: _____

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