Chinook Respiratory Care

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RESPIRATORY REQUISITION / REFERRAL FORM

SLEEP APNEA ~ CARDIO - PULMONARY DIAGNOSTICS ~ OXYGEN

Patient Information (or Patient Label)

Last name _____ **First** _____ **Gender** M _____ F _____

Address _____ **City** _____ **Postal Code** _____

Height _____ **Weight** _____ **BMI** _____ **Phone (daytime)** _____

D.O.B. (DD/MM/YY) _____ (DD / MM / YY) _____ **AHC#** _____

MEDICAL HISTORY _____

RESPIRATORY

☐ Assess for Home Oxygen
- ☐ Room air at rest
- ☐ Exertion
- ☐ Nocturnal
- ☐ Palliative _____ Diagnosis _____

☐ Arterial Blood Gas
Book if needed after home assessment

☐ Home Oxygen Therapy
- ☐ Keep SpO2>90%
- ☐ _____ LPM _____ hrs/day

☐ Suction Equipment

☐ Aerosol Compressor

SLEEP THERAPY

☐ Level 3 Sleep Screening
With a positive diagnosis, as determined by the interpreting physician, start a two-week Auto CPAP trial.

6 min. pressure 20 max. pressure

or specify.

_____ min. pressure _____ max. pressure

☐ Attached, copy of Sleep Screen with interpretation; proceed with the following:
- ☐ Auto CPAP Therapy
  _____ min. pressure _____ max. pressure
- ☐ CPAP Therapy
  _____ fixed pressure

Office Phone: _____ Office Fax: _____

Office Name: _____

Referred by Dr: _____ _____ Date: DD/MM/YYYY _____

Physician's Signature — PLEASE Print Name — DD/MM/YY

OPTIONAL CLINIC STAMP

Our Consistent Care is at the heart of Your Home Health

FAX Form to: 403-329-9128 *Chinook Respiratory Care*