VitalAire Home Healthcare

ACCREDITED ACCREDITATION AGREMENT CANADA

Addressograph

HOME RESPIRATORY REFERRAL

FAX TO 1 866 233 9926 during regular business hours
For after hours service, please PHONE 1 800 567 0202

Patient information

Last Name:	First Name:	☐ Male ☐ Female	
Address:			
City:	Prov:	Postal Code:	
Phone:	HC#	DOB: MM/DD/YYYY	
Contact Name:	Contact Phone:		
Diagnosis:			

Referral Source Information

Last name:	First name:	Tel:	Title:
Facility or Address:			

Home Oxygen Assessment & Setup

☐ Oximetry (this may include oximetry at rest, exertion and/or nocturnal on room air)

☐ Perform room air Arterial Blood Gas (ABG) to confirm funding eligibility (not offered in every location)

Home Oxygen Therapy

☐ Initiate Home O2 therapy	Rest:	lpm	h/day
	Exertion:	lpm	h/day
	Nocturnal:	lpm	h/day

Qualifying Room air ABG (if ABG not done on room air, O2% or lpm)
Date: MM/DD/YYYY pH: paCO2: paO2: SaO2:

☐ Initiate Palliative O2 therapy lpm h/day

Special Instructions

Physician Name: _____
Practitioner ID #: (required) _____
Physician Signature: (required) _____
Date: MM/DD/YYYY _____

Clinic Stamp