

PAP Therapy Referral

Addressograph

Patient Information

Name: (Last) _____ (First) _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: (MM/DD/YYYY) _____ Health Insurance #: _____ VC: _____

Home Phone: _____ Work Phone: _____ Family Contact Phone: _____

Diagnosis: _____ AHI: _____ Male Female

Referral Information

Physician: _____ Phone: _____ Fax: _____

Sleep Lab: _____ Address: _____ Fax: _____

Assessment: Overnight Oximetry Other _____

Treatment Trial Purchase

CPAP

APAP

Bilevel

Bilevel Auto

Bilevel S/T - Trial or rental only

Servo Ventilator

Settings:

Special Instructions (mask, pressure relief, etc):

CPAP Re-assessment / Other:

I have obtained written consent from the patient agreeing to the collection, use and disclosure of his/her information to VitalAire Canada Inc.

Physician Name: _____ Date: M / D / Y _____

Signature: _____ Phone: _____ Fax: _____

ON PAP Therapy Referral (01/01/2021) REL

Fax to VitalAire 1 866 233 9926 OR Phone 1 833 904 2473