RESET

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: ( ) Ext 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: ( )

06/06/2013 12:46 pm

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

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

EMAIL PRINT