



## HOME RESPIRATORY REFERRAL

During normal business hour, **fax** to VitalAire at **1-866-233-9926**. For after hours service, please **call** 1-833-904-2473

Patient information				
Last Name		First Name		
Address		City	Province	
Postal Code	Primary Telephone	Health Card Number	Date of Birth (MM/DD/YYYY)	
Diagnosis			Palliative <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alternate Contact Name			Phone	
Physician/Nurse Practitioner. Please complete prescription				
<input type="checkbox"/> Respiratory Assessment (this may include oximetry at rest, exertion and/or nocturnal on room air)				
<input type="checkbox"/> Home Oxygen Therapy				
Rest	lpm	h/day	Comments/Special Instructions	
Exertion	lpm	h/day		
Nocturnal	lpm	h/day		
<input type="checkbox"/> Other Respiratory Therapy		Please specify		
For Provincial Funding				
Qualifying ABG Date (MM/DD/YYYY)				
Results: pH _____ PO <sub>2</sub> _____ PCO <sub>2</sub> _____ SaO <sub>2</sub> _____ %				
<input type="checkbox"/> ABG could not be taken due to medical risk		Reason (must specify)		
Prescriber Information				
Physician/Nurse Practitioner Name			Clinic/Office Stamp	
Physician/Nurse Practitioner Signature				
Phone number	Date (MM/DD/YYYY)			

**A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER**