



Addressograph

HOME RESPIRATORY REFERRAL

Fax to 1-866-489-0202 or Phone 1-833-904-2473 • www.vitalaire.ca

Patient information

Last Name: _____ First Name: _____ Male Female

Address: _____

City: _____ Postal Code: _____ DOB: **MM/DD/YY**

Home Phone: _____ Work Phone: _____ Health Insurance #: _____

Alternate Contact Name: _____ Contact Phone: _____

Diagnosis:

Sleep Apnea Assessment (optional)

Refer for assessment if 3 or more boxes are checked

SYMPTOMS / COMORBIDITIES

- Loud disruptive snoring
- Witnessed Apneas
- Excessive daytime sleepiness
- Wake up unrefreshed / excessive daytime fatigue
- Large neck size (>17" in men OR >16" in women)
- BMI > 30

PAST MEDICAL HISTORY

- Hypertension
- Diabetes
- Metabolic Syndrome
- Arrhythmias, CAD, Hx CVA
- Coronary Artery Disease
- Cardiovascular Disease
- COPD
- Anxiety/Depression

Sleep Apnea Diagnostics and Treatment

REFERRAL:

Please check **one** of the following:

- Level 3 Sleep Study and AutoPAP Trial/Treatment
- CPAP/APAP Therapy Bi level A Servo-Ventilation
- Consultation with Dr. Gosia Phillips, Sleep Medical Specialist

COPD Screener:

Refer for assessment if 1 or more boxes are checked

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you cough up phlegm regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do even simple chores make you short of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you wheeze when you exert yourself (exercise, go up stairs?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you a smoker or ex-smoker? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you older than 40 years old? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a respiratory related hospital admission? | <input type="checkbox"/> | <input type="checkbox"/> |

Diagnosis:

Home Oxygen Referral:

- Oxygen Assessment Humidified High Flow Therapy
- Overnight Oximetry OPEP Therapy

Home Oxygen Rx

Special Instructions

Clinic Stamp

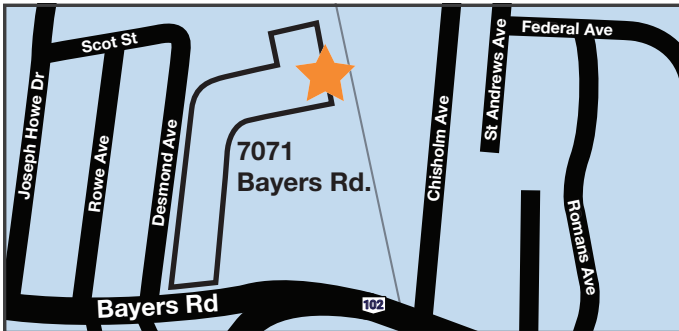
I have obtained written consent from the patient agreeing to the collection, use and disclosure of his/her information to VitalAire Canada Inc.

Physician/Professional Name: _____ Date: MM / DD / YYYY

Signature: _____ Phone: _____ Fax: _____

Our referral form can be found on all Nova Scotia EMR platforms

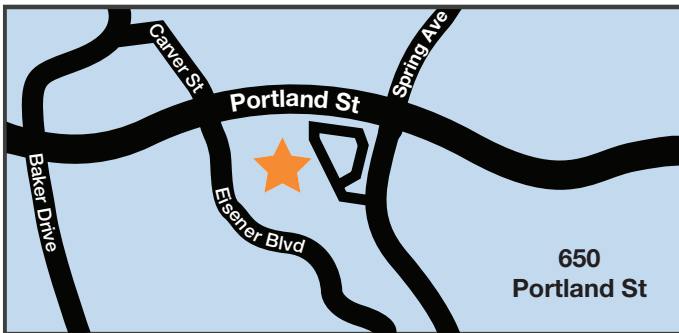
LOCATIONS



HALIFAX: 7071 Bayers Rd., Suite 140
Halifax, NS B3L 2C2
Phone: (902) 450-5162



ANTIGONISH: 133 Church St
Antigonish, NS B2G 2E4
Phone: (902) 867 0413



DARTMOUTH: 650 Portland Street, Unit 115A
Dartmouth, NS B2W 6A3
Phone: (902) 450-5162



SYDNEY: 200 Churchill Dr #105,
Sydney, NS B1S 0H5
Phone: (782) 977-0503



STELLARTON: 91 Lawrence Blvd. Unit 1D
Stellarton, NS B0K 1S0
Phone: (902) 752-4117