



Addressograph

HOME RESPIRATORY REFERRAL

FAX TO 1 866 233 9926 during regular business hours
For after hours service, please PHONE 1-833-904-AIRE (2473)

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

Patient also referred to Covid Care @ Home

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

Clinic Stamp