ProResp Inc.
Community Respiratory Therapy

PRIMARY CARE COVID MANAGEMENT OXYGEN THERAPY PRESCRIPTION

Please fax this form to: **905-529-2224**

For after hours service please call: **905-529-2166**

PATIENT INFORMATION

Patient's Name: _____ Address: _____
NUMBER STREET APARTMENT

Date of Birth: _____
YYYY MM DD

_____
CITY PROVINCE POSTAL CODE

Health Card #: _____ Telephone #: _____

Next of Kin: _____ Telephone #: _____

DIAGNOSIS

☐ COVID +ve _____

☐ Palliative _____

☐ _____

ROOM AIR ABGs (CHRONIC) Not Required

Date: _____ PaO_2 _____
YYYY MM DD

$PaCO_2$ _____ pH _____

SaO_2 _____ HCO_2 _____

OXYGEN PRESCRIPTION

Oxygen: _____ (litres/minute)

☐ Up to 24 hrs/day

☐ Wean as tolerated

OXIMETRY TESTING

☐ Maintain oxygen saturations 92-96%

☐ Maintain oxygen saturations at _____% (underlying lung disease)

ADDITIONAL INFORMATION

Does patient require O_2 from hospital to home: ☐ YES ☐ NO

Hospital Name: _____ Discharge Date: _____
YYYY MM DD

☐ Patient also referred to COVID Care @ Home Program

PRESCRIBER SIGN OFF

My signature confirms that I have obtained consent from the patient to collect, use & disclose his/her personal information to ProResp inc.

X _____ _____ ☐ Physician ☐ Nurse Practitioner
Prescriber Signature Prescriber Name

Prescriber ID#: _____ Date: _____
YYYY MM DD

For oxygen therapy please advise patient that **set-up can be completed the day** you send the referral.