ProResp Inc.
Community Respiratory Therapy

RESPIRATORY THERAPY PRESCRIPTION

Please fax this form to: 905-529-2224

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

Hamilton

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

_____

_____

☐ Palliative ☐ Acute O_2 Need ☐ Chronic O_2 Need

ROOM AIR ABGs (CHRONIC)

Date: _____ PaO_2 _____
YYYY MM DD

$PaCO_2$ _____ pH _____

SaO_2 _____ HCO_2 _____

OXYGEN THERAPY

Hours of use per day: _____

Nasal Cannula: _____ (litres/minute)

OXIMETRY TESTING (in Family Practice or Outpatient setting)

Testing on room air unless specified otherwise:

_____ % Daytime Resting

Doctor, Nurse Practitioner or Reg.Health Professional Signature:

_____

ADDITIONAL INFORMATION (as applicable)

Does patient require O_2 from hospital to home: ☐ YES ☐ NO Hospital Name: _____ Discharge Date: _____
YYYY MM DD

_____

OSCILLATING PEP THERAPY

☐ AerobiKA

Aerobika* Oscillating PEP Therapy Device is a drug-free, easy to use, hand-held device that helps people with COPD and other respiratory conditions, with secretion clearance and lung recruitment.

CPAP THERAPY

Pressure: _____ cm H_2O Comments: _____

_____

PRESCRIBER SIGN OFF

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

If completed by other: _____ Date: _____
NAME DESIGNATION TELEPHONE# YYYY MM DD

Primary Care Provider Name: _____

For Oxygen Therapy please advise patient that set-up can be completed the day you send us the referral.

Rev. 2021/10/18