

RESPIRATORY & SLEEP REQUISITION

Phone: (877) 467-0202
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 rhscanada.com



Oxygen Therapy | Sleep Screening & Therapy

Patient Information

Last Name: _____
 First Name: _____
 Sex M F | Date of Birth (mm/dd/yy): _____
 Address: _____

 Phone (Daytime): _____
 Email: _____
 Health Card #: _____

Patient Label

OXYGEN

Diagnosis: _____
O₂ Flow Rate:
 Rest: _____ Exertion: _____
 Sleep: _____ OR Keep SpO₂>: _____ %
 ABG Results:
 pH _____; PaCO₂ _____; PaO₂ _____; SaO₂ _____; HCO₃ _____

Funding Category

- Short term oxygen therapy
- PaO₂ ≤ 55 mmHg or SaO₂ ≤ 88%
- PaO₂ 56 – 60 mmHg (SaO₂ 89-90%) in presence of:
 - Cor Pulmonale, Pulmonary Hypertension or Persistent Erythrocytosis OR
 - Exercise Limited Hypoxemia (exertional test) OR
 - Nocturnal Hypoxemia
- PaO₂ > 60 mmHg (SaO₂ > 90%) with an Independent Exercise Assessment (IEA)
- Palliative oxygen funding for a max of 90 days

RESPIRATORY EQUIPMENT

- Diagnosis: _____
- Portable Aerosol Compressor CPAP
 - Stationary Aerosol Compressor BiPAP
 - Suction Therapy APAP
 - Humidity Therapy ASV

DIAGNOSTICS

- Overnight Oximetry
- In Home Sleep Apnea & Snoring Screening
- Oxygen Assessment (ABG/IEA)

Medical Hx / Notes: _____

- Snoring Hypertension Diabetes Cardiovascular Disease

Referring Physician/Practitioner Information

- Please confirm receipt of fax

Clinic Stamp Including Fax #

Name: _____
 Signature: _____
 Prac ID: _____
 Date: _____
 Fax Mandatory: _____
 Phone: _____
 Clinic: _____

- Please forward screening results to treating physician. (If checked please include the following information):

Name: _____ Fax: _____ Clinic: _____