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Referral | Requisition of Services

Please Fax the referral form to 1-866-896-1301 or E-Mail to cpap@capitalhme.ca

Patient Information

First Name		Last Name		Sex	M	F	Date of Birth (DD/MM/YY)
Address		City	Province	Postal Code		Health Card Number	
Telephone		Email		Diagnosis/ Comments			

Home Sleep Testing: Level III

All the following are required to proceed with a Home Sleep Apnea Test:

The patient must be over 13 years of age

The patient does not have significant cardiac, pulmonary or neuromuscular disease

The patient does not have any other known and diagnosed sleep disorder (Narcolepsy, PLM, Etc)

Indications for Testing:

<input type="checkbox"/> Snoring	<input type="checkbox"/> Fatigue Related Accident
<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Non-Restorative Sleep
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Abnormal Airway
<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Pre-Surgery
<input type="checkbox"/> Witnessed Apneas	<input type="checkbox"/> Post Surgery Follow Up
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Significant weight loss	<input type="checkbox"/> Other: _____

Screening Tool: STOP-BANG *One point for each*

Snoring Tired Observed apneas Pressure

BMI >35 Age >50 Neck >40cm (17in) Gender-male

STOP-BANG Score= /8

OSA risk by SB score: <2 3-4 >5

Low Mid High

Please implement the Sleep Medicine Physician's therapy recommendations.

Respiratory | Oxygen Assessment & Therapy

Respiratory & Oxygen assessment (Private):
Initial assessment: Medical intake, auscultation, 6-minute walk test, overnight oximetry.

Include full Home Sleep Apnea test. (Available with a cost)

Home Oxygen Therapy:
Maintain SpO2 >90% or between ___-___%

Specific Requests:

Stationary Concentrator

Portable Oxygen Concentrator

Oxygen Accessories: Patient should replace oxygen tubing, cannulas and filters as per manufacturer's guidelines and as needed.

COPD Management

Respiratory Services & Products (Includes product education):

<p>Therapy products</p> <p><input type="checkbox"/> Spacer (AeroChamber)</p> <p><input type="checkbox"/> OPEP devices (Aerobika)</p> <p><input type="checkbox"/> Nebulizers & supplies</p> <p><input type="checkbox"/> Incentive Spirometry</p> <p><input type="checkbox"/> Spirometer</p> <p><input type="checkbox"/> Peak Flow Meter</p> <p><input type="checkbox"/> Lung rehabilitation supplies</p> <p><input type="checkbox"/> Tracheotomy supplies</p> <p><input type="checkbox"/> Suction Supplies</p>	<p>Services</p> <p><input type="checkbox"/> Spacer Technique</p> <p><input type="checkbox"/> Smoking Cessation</p> <p><input type="checkbox"/> Medication Overview</p> <p><input type="checkbox"/> In-Check Dial Assessment</p>
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Comments

Physician/Nurse Practitioner Name: _____ Tel/fax: _____ / _____

Physician/Nurse Practitioner Signature: _____ Date: _____

A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.