CAPITAL HOME MEDICAL EQUIPMENT

Downtown
202- 267 O'Connor Street
Ottawa, ON K2P 1V3
T: 613-695-2733
F:1-866-896-1301
cpap@capitalhme.ca

West End
27A 2194 Robertson Rd.
Nepean, ON K2H 9J5
T: 613-721-2733
F:1-866-896-1301
cpap@capitalhme.ca

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:

☐ Snoring	☐ Fatigue Related Accident
☐ Drowsiness	☐ Non-Restorative Sleep
☐ Hypertension	☐ Obesity
☐ Diabetes	☐ Abnormal Airway
☐ Morning Headaches	☐ Pre-Surgery
☐ Witnessed Apneas	☐ Post Surgery Follow Up
☐ Chronic Fatigue	☐ Insomnia
☐ Significant weight loss	☐ Other:_____

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

Snoring **T**ired **O**bserved **a**pneas **P**ressure

BMI >35 **A**ge >50 **N**eck >40cm (17in) **G**ender-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 Sp02 >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.*

☐ ***Spirometry: Flow Volume Loop*** ☐ ***Pre & Post Bronchodilator***

☐ ***Respiratory Services & Products (Includes product education):***

Therapy products	*Educational Services*
☐ *Spacer (AeroChamber)*	☐ *Spacer Technique*
☐ *OPEP devices (Aerobika)*	☐ *Smoking Cessation*
☐ *Nebulizers & supplies*	☐ *Medication Overview*
☐ *Incentive Spirometry*	☐ *In-Check Dial Assessment*
☐ *Spirometer*	
☐ *Peak Flow Meter*	
☐ *Lung rehabilitation supplies*	
☐ *Tracheotomy supplies*	
☐ *Suction Supplies*	

Comments

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

Physician/Nurse Practitioner Signature:_____ **Date:**_____

A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER