Medigas
A Linde company

CLEAR ALL

RESPIRATORY REFERRAL / REQUISITION OF SERVICES

During normal business hours, fax to Medigas at **1-855-233-1160** For after hours service, please call 1-866-446-6302

PATIENT INFORMATION *(please print)*

Last Name	First Name	Sex ☐ M ☐ F
Address	City / Prov. / Postal Code	
Primary Tel.	Health Card Number	Date of Birth mm / dd / yyyy
Diagnosis		Palliative ☐ YES ☐ NO

PHYSICIAN/NURSE PRACTITIONER: PLEASE COMPLETE APPLICABLE PRESCRIPTION(S)

RESPIRATORY

☐ Respiratory Assessment: may include oximetry testing on room air at rest, on exertion and/or nocturnal

☐ Home Oxygen Therapy

Maintain SpO_2 > 89 %,
or between_____- _____%

OR

Rest: ____LPM ____hours/day

Exertion: ____LPM ____hours/day

Nocturnal: ____LPM ____hours/day

☐ COPD Management

☐ Other Respiratory Therapy *(specify)*

_____

For provincial funding in AB, ON & SK only

Qualifying ABG Date _____ mm / dd / yyyy

Results: pH _____ PO_2 ____ PCO_2 ____ SaO_2 _____%

☐ ABG could not be taken due to medical risk

Reason (specify) _____

SLEEP

☐ Level III Home Sleep Screening*: with a positive outcome to sleep screening, as determined by interpreting physician, initiate auto-titration CPAP trial using the following limits:

__4__ Min. Pressure __20__ Max. pressure

OR

_____ Min. Pressure _____ Max. pressure

*** Level I testing is required in ON & SK for provincial government funding of PAP therapy**

(Following Auto-titration CPAP trial)

☐ Auto CPAP Therapy

Min Pressure _____ Max Pressure _____

Auto CPAP may be changed to standard CPAP based on auto-titration average pressure for 90% of titration time

☐ CPAP Therapy

_____ cm H_2O _____ Ramp (minutes)

☐ STAR™ Program
Patient re-education, CBT techniques, equipment performance verification, compliance data monitoring

COMMENTS/SPECIAL INSTRUCTIONS:

Physician/Nurse Practitioner Name _____ **Tel.** _____

Physician/Nurse Practitioner Signature _____ **Date** mm / dd / yyyy

A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER