Medigas
A Linde company

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

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PATIENT INFORMATION *(please print)*

Last Name	First Name	Sex ❑ M ❑ F

Address	City	Prov.	Postal Code

Primary Tel.	Health Card Number	Date of Birth

Diagnosis	Palliative ❑ YES ❑ NO

PHYSICIAN/NURSE PRACTICTIONER: PLEASE COMPLETE APPLICAPLE 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 ______________________

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** ______________

A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER