



# RESPIRATORY THERAPY PRESCRIPTION

Please fax this form to: **705-523-9500**

For after hours service please call: **705-523-9400**

**Sudbury**

## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
NUMBER STREET APARTMENT

Date of Birth: \_\_\_\_\_  
YYYY MM DD CITY PROVINCE POSTAL CODE

Health Card #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Telephone #: \_\_\_\_\_

## DIAGNOSIS

\_\_\_\_\_  
\_\_\_\_\_  
 Palliative     Acute O<sub>2</sub> Need     Chronic O<sub>2</sub> Need

## ROOM AIR ABGs (CHRONIC)

Date: \_\_\_\_\_  
YYYY MM DD    PaO<sub>2</sub> \_\_\_\_\_  
PaCO<sub>2</sub> \_\_\_\_\_    pH \_\_\_\_\_  
SaO<sub>2</sub> \_\_\_\_\_    HCO<sub>3</sub> \_\_\_\_\_

## OSCILLATING PEP THERAPY



Aerobika\* Oscillating PEP Therapy Device is a drug-free, easy to use, hand-held device that helps people with COPD and other respiratory conditions, breathe easier and live better.

## OXYGEN THERAPY

Hours of use per day: \_\_\_\_\_  
Nasal Cannula: \_\_\_\_\_ (litres/minute)

## OXIMETRY TESTING

Testing on room air unless specified otherwise:  
\_\_\_\_\_  
 Daytime Resting     Daytime Exertion     Nocturnal (Sleep)

## ADDITIONAL INFORMATION

Does patient require O<sub>2</sub> from hospital to home:     YES     NO    Hospital Name: \_\_\_\_\_    Discharge Date: \_\_\_\_\_  
YYYY MM DD

## CPAP THERAPY

Pressure: \_\_\_\_\_ cm H<sub>2</sub>O    Comments: \_\_\_\_\_

## PRESCRIBER SIGN OFF

X \_\_\_\_\_    \_\_\_\_\_     Physician     Nurse Practitioner  
Prescriber Signature    Prescriber Name

If completed by other: \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    Date: \_\_\_\_\_  
NAME DESIGNATION TELEPHONE# YYYY MM DD

Primary Care Provider Name: \_\_\_\_\_

**For Oxygen Therapy please advise patient that set-up can be completed the day you send us the referral.**