Horizon PRORESP Inc.
Community Respiratory Therapy

Stratford

RESPIRATORY THERAPY PRESCRIPTION

Please fax this form to: 519-272-0262

For after hours service please call: 519-272-0202

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_2 Need ☐ Chronic O_2 Need

ROOM AIR ABGs (CHRONIC)

Date: _____ PaO_2 _____
YYYY MM DD

$PaCO_2$ _____ pH _____

SaO_2 _____ HCO_3 _____

OSCILLATING PEP THERAPY

☐ AerobiKA

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_2 from hospital to home: ☐ YES ☐ NO Hospital Name: _____ Discharge Date: _____
YYYY MM DD

CPAP THERAPY

Pressure: _____ cm H_2O 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.

Rev. 2019/08/14