ProResp Inc.
Community Respiratory Therapy

North Bay

# RESPIRATORY THERAPY PRESCRIPTION

**Please fax this form to: 705-474-5859**

**For after hours service please call: 705-474-5600**

## 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