



RESPIRATORY THERAPY PRESCRIPTION

Please fax this form to: **519-272-0262**

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

Stratford

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 O₂ Need Chronic O₂ Need

ROOM AIR ABGs (CHRONIC)

Date: _____
YYYY MM DD PaO₂ _____
PaCO₂ _____ pH _____
SaO₂ _____ HCO₃ _____

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 O₂ from hospital to home: YES NO Hospital Name: _____ Discharge Date: _____
YYYY MM DD

CPAP THERAPY

Pressure: _____ cm H₂O Comments: _____

PRESCRIBER SIGN OFF

X _____
Prescriber Signature Prescriber Name Physician Nurse Practitioner

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.