

# RESPIRATORY THERAPY PRESCRIPTION

Please fax this form to: **416-632-8711**

For after hours service please call: **416-632-8700**

## North York

### 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 \_\_\_\_\_  
 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.**