Respiratory Services Referral Form

ALPINE HEALTHCARE

Addressograph

604-574-2967 | support@alpinehealthcare.ca | 604-644-5537

Patient Information

Name: (Last) (First)

Address: City: Postal Code:

Date of Birth: (YYY/MM/DD) PHN: Funding Agency / EHB Provider :

Home Phone: Work Phone: Family Contact Name &Phone #:

Diagnosis:

Email: Gender: -

☐ Oxygen Therapy Rx:

Rest: ____ Lpm Exertional: ____Lpm Nocturnal:____Lpm

RRT to titrate O2 to maintain SpO2 in ideal range
Unless otherwise indicated

☐ CPAP

Fixed Pressure _____ cmH2O

Auto Pmin _____cmH2O

Pmax _____cmH2O

☐ Clinician to titrate PAP settings as appropriate

☐ Bi-Level / BiPAP - Mode: (spont, auto, timed, AVAPS, ASV)

Parameters (IPAP,EPAP, BUR, PS(min/max) etc)

Interface: ☐ Nasal Pillows ☐ Nasal Mask ☐ Full Face Mask - Size

☐ myAirvo 2 Therapy:

☐ As Tolerated

Temp: _____ °C

Flow: _____ Lpm

Interface

Optiflow Nasal Cannula: ☐ Small ☐ Medium ☐ Large

☐ Face Mask

☐ Trach Mask

☐ Trach-Direct Connect

☐ Cough Assist

☐ As Tolerated

Insufflation Pressure _____ **cmH2O**

Exsufflation Pressure _____ **cmH2O**

Frequency _____ **Hz**

Amplitude _____

☐ Suction (portable)

Size of suction catheters (fr) _____ Qty _____

☐ Ventilator

Please call Alpine Healthcare to discuss your patient for equipment & supply options

If you are unsure of the exact size & quantity of items your patient may need,or, require related items not listed, please contact us for assistance

Special Instructions:

Referred By: Designation: Phone:

Physician / HCP with designation : Date:

Signature: Phone: Fax: