Alpine HEALTHCARE

Phone: 604 644 5537
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alpinehealthcare.ca

Respiratory Services Referral Form

Patient Information

First Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: _____ PHN: _____

Home Phone: _____ Work Phone: _____

Family Contact Name and Phone Number: _____

Email: _____ Gender: ☐ Male ☐ Female ☐ Other

Diagnosis

☐ **Oxygen Therapy Rx**

Rest: _____ Lpm Exertional: _____ Lpm

Nocturnal: _____ Lpm

☐ **CPAP**

Fixed Pressure: _____ cmH_2O

Pmin: _____ cmH_2O

Pmax: _____ cmH_2O

☐ **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**

Temp: _____ °C Flow: _____ Lpm

INTERFACE:

Optiflow Nasal Cannual: ☐ Small ☐ Medium ☐ Large

☐ Face Mask ☐ Mask interface with trach mask

☐ Trach Direct Connect

☐ **Cough Assist**

Insufflation Pressure: _____ cmH_2O

Exsufflation Pressure: _____ cmH_2O

Frequency: _____ Amplitude: _____

☐ **Suction Machine**

Size of suction catheters (fr): _____ Qty: _____

☐ **Ventilators**

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: _____