RESPIRATORY WELLNESS Corp.
5144 - 50 Ave, Vegreville, Alberta
Your Trusted Respiratory Professionals

Tel: 780 409 3930
Fax: 780 409 3931
Email: referrals@respiratorywellness.ca

Respiratory & Sleep Requisition

Patient Information (Please print or affix label)

Last Name _____ Sex at Birth _____

First Name _____ Prov. Health # _____

Address _____ Phone (daytime) _____

Email address: _____ Phone (alternate) _____

Sleep

- ☐ **Home Sleep Apnea Test (Level 3) and APAP/CPAP Treatment Pressure _____ cmH2O**
- ☐ **APAP/CPAP Treatment Pressure _____cmH2O**
- ☐ **APAP/CPAP Mask and Supplies**
- ☐ **Reassessment of Treatment HSAT and/or CPAP/APAP**
- ☐ **Home Polysomnography Level 2**
- ☐ **Polysomnography Level 1**
- ☐ **Bilevel Therapy Insp/Exp _____cmH2O**
- ☐ **Pediatric Nocturnal Oximetry**

Pulmonary Function

- ☐ **Respiratory Assessment (which may include any below)**
- ☐ **Pulmonary Function Study Pre/Post Bronchodilator 400ug Salbutamol**
- ☐ **Spirometry Pre/Post Bronchodilator 400ug Salbutamol**
- ☐ **Oximetry Rest/Exertion/6 min walk**
- ☐ **Arterial Blood Gas (ABG)**
  Room Air _____ 02 LPM ____
  Pa02 < 56 mmHg start Home02
- ☐ **Respiratory Consult**
  Attach Referral Letter (Respirologist)

Other

- ☐ **Holter Monitoring**
  (Site specific)
- ☐ **Other** _____
  Please specify

Respiratory

- ☐ **Home 02 Assessment**
  Assess Home O2 Requirement
- ☐ **Oxygen Therapy**
  Maintain SP02>89% (+/–)
  ABG, PFT, HSAT, Level III
- ☐ **Exertional Walk Test**
- ☐ **Palliative Oxygen Therapy Comfort Care**
  Diagnosis _____

Education / Wellness

- ☐ **Pulmonary Rehabilitation**
- ☐ **COPD/Asthma Action Plan**
- ☐ **CPAP/Sleep**

SPECIAL REQUESTS

MEDICAL Hx/Notes

ALLERGIES

Clinic and Referring Physician

Clinic Name _____ Date of Referral _____

Clinic Phone _____ Clinic Fax _____

Referring Physician/NP _____ Signature _____
Print Name

Prac ID# _____