MedPro Respiratory Care
When every breath matters...™

Name:
DOB:
PHN:
Address:
City:
Phone:

Date results required by: _____

Complete and fax to 604-521-9286
We will contact the patient.

Respiratory Services Requisition

British Columbia

CPAP/Bi-Level Therapy Prescription

☐ **CPAP:** _____ H_2O

☐ **Auto-Titrating CPAP:** Pressure Range _____ to _____ cmH_20

☐ **Bi-Level:** IPAP _____ EPAP _____ Rate _____

☐ **Other - Please Specify:** _____

This patient is under my care for treatment of obstructive sleep apnea which is associated with serious cardiovascular morbidity and reduced survival if left untreated. In order to pursue treatment, a CPAP device, mask interface, hose and humidifier must be purchased. Treatment is intended to be used every night, indefinitely.

Home Oxygen Assessment and Therapy

☐ **Home Oxygen Assessment (stable patients only)**

Note: May include oximetry at rest, exertion and nocturnal

ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGREMENT CANADA

☐ **Home Oxygen Therapy**

Oxygen prescription _____ LPM _____ Hours/Day

If oxygen prescription varies

Rest _____ LPM
Exertion _____ LPM
Nocturnal _____ LPM

This patient is under my care for treatment of chronic hypoxemia which is associated with serious cardiovascular morbidity and reduced survival if left untreated. In order to pursue treatment this patient will be required to rent or purchase oxygen equipment for treatment at home. Treatment is intended to be used daily, indefinitely.

Reason for referral: _____

Primary Diagnosis: _____

Notes: _____

Ordering Physician **MSP #** **Signature:**

Fax # **Phone #** **Date**

Vancouver Island	BC Interior	Metro Vancouver / Fraser Valley
Victoria	Penticton	Vancouver
Colwood	Kamloops	Surrey
Nanaimo	Kelowna	Langley
Duncan (Warehouse)	Prince George	Abbotsford
	Castlegar	
	Cranbrook	

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