MedPro Respiratory Care
When every breath matters...™

Date results required by: _____

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

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

Respiratory Services Requisition

British Columbia

PAP Prescription

☐ **CPAP:** _____ H_2O

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

☐ **Initiate PAP Therapy** (Polysomnography results & Specialist Consult/RX attached) _____

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**

Multiple Convenient Locations Across British Columbia

Vancouver Island **Metro Vancouver / Fraser Valley** **BC Interior**

Phone 604-526-0208 • Toll Free Phone 1-888-310-1444 • Fax 604-521-9286
www.medprorespiratory.com