ProResp Inc.
Home Oxygen & Respiratory Care

COMPLETE HEALTHCARE SOLUTIONS
LIVE LIFE WELL

2123 Algonquin Avenue, North Bay, ON P1B 4Z3 • Tel: 705-474-5600 • Fax To: 705-474-5859

PATIENT REFERRAL FORM

Patient Name: _____

Gender: **Male:** ☐ **Female:** ☐

Patient Address: _____

_____

Telephone #: _____

Health Card #: _____

Date of Birth: _____

Comments: _____

_____

_____

Date: _____

Physician Name: _____

Address: _____

_____

Telephone #: _____

Fax #: _____

Diagnosis: _____

_____

_____

_____

HOME OXYGEN

☐ **Home Oxygen Assessment**
(oximetry and/or Arterial Blood Gases if required)

☐ **Palliative Home Oxygen Set Up**

SLEEP THERAPY

☐ **Sleep Apnea** (pre-screening)

☐ **CPAP Trial***

☐ **CPAP/BIPAP Set Up***

☐ **Auto CPAP Trial***
(*initial diagnostic study required)

Physician's/Nurse Practitioner's Signature: _____

CONSIDERED A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN/NURSE PRACTITIONER
(Service Bilingue)