PARKLAND RESPIRATORY CARE

Date: Form Completed By:

Patient Name: Date of Birth:

Address: City: Postal Code:

PHN: Cell Phone: Home Phone:

Diagnosis:

Remarks:

Level III Sleep Study

☐Without Interpretation ☐ With Interpretation

☐Room Air ☐O2 ☐CPAP/BPAP

CPAP/BPAP Therapy

☐Auto CPAP Titration ☐Auto BPAP Titration

☐CPAP Therapy at _____ cm H_2O

☐Auto CPAP at _____ cm H_2O

☐BPAP Therapy ☐S ☐ST ☐PC ☐AVAPS ☐ASV

IPAP (min) _____ IPAP (max) ____ EPAP ___ cmH20

Back up rate ____Vt ___Rise time ____ O_2 ___ lpm

Other Therapy

☐Suction Therapy ☐High Humidity Therapy

☐Aerosol Therapy (Side Stream Nebulization)

☐Aerobika (PEP Device) ☐Trach Tubes

Oxygen Therapy Assessment

☐Pulse Oximetry/Respiratory Assessment

☐At Rest ☐On Exertion ☐ABG ☐Walk Test

☐Contact Physician with oximetry results prior to initiating O_2 Therapy

Oxygen Therapy

☐Initiate Home O_2 Therapy to maintain patient O_2 saturation > 89%

☐Initial Home O_2 Therapy for Palliative Care

☐Flow Rate: _____ LPM _____ Hours

Pulmonary Function Testing

☐PFT with Interpretation

RESULT TO BE

☑FAXED ☐PHONED ☐URGENT

Referral Physician: **Physician Signature: _____**

Physician Phone #: **Physician Fax #:**

	Edmonton South ☑ Head Office	Edmonton North ☐	Spruce Grove ☐	Red Deer ☐	Grande Prairie ☐	Calgary ☐
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