FreshAir Respiratory Care Inc.
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Edmonton, AB T5S 1H4
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FreshAir Respiratory Care Inc.

Oxygen Therapy | Sleep Diagnostics & Treatment | Pulmonary Diagnostics

Patient Information or Patient Label

First Name: _____ **Last Name**: _____
PHN: _____ **Address**: _____
Sex: ☐ M ☐ F | **Date of Birth (mm/dd/yy)**: _____
Phone: (Primary) _____ **Phone**: (Other) _____
Email: _____ **Preferred Method of Contact**: _____

Diagnosis: _____

Medical History/Notes/Pertinent Medications/Special Instructions:

☐ Hypertension ☐ Snoring ☐ Diabetes ☐ Cardiovascular Disease ☐ Smoking History

OXYGEN THERAPY

- ☐ **Home Oxygen Assessment** (ABG, PFT, Oximetry as per AADL guidelines – Initiate oxygen therapy to maintain Sp02>89% if AADL funding guidelines are met)
- ☐ **Assess to challenge AADL Walk Test for oxygen funding**.

SLEEP APNEA TESTING & TREATMENT

- ☐ **Level 3 Sleep Study** (Include CPAP/APAP trial if indicated in interpretation)
- ☐ **CPAP Re-assessment** (May include CPAP/APAP trial or repeat level 3 sleep study as indicated)

DIAGNOSTICS

- ☐ **Arterial Blood Gas (ABG)** – Start home oxygen if P02 < 60
- ☐ **Complete Pulmonary Function Test**
- ☐ **Pulmonary Consult**

Referring Physician Information/Clinic Stamp:

Physician Name: _____
Clinic Address: _____
Clinic Phone Number: _____
Clinic Fax Number: _____
Date: _____

Physician Signature: _____

☐ **Copy results to:**
Name: _____
Phone: _____
Fax: _____

Incomplete forms may result in delay of service. Please be advised that FreshAir may contact your clinic for additional information FARC 09/2019