St.Thomas Elgin General Hospital

RESPIRATORY HOME SERVICES REFERAL FORM

189 Elm Street, St.Thomas, ON N5R 5C4
Ph: 519-631-2020 x 2410 Fax: 519-631-5464
AFTER HOURS – (519)-631-2030 - 0 for Switchboard

PATIENT INFORMATION

DATE_____ SE#_____ ☐ M ☐ F

CLIENT NAME:_____ D.O.B (M/D/Y) _____

ADDRESS:_____

STREET CITY PROV POSTAL CODE

HOME PHONE :(____)_____ CELL # : (___)_____

HEALTH CARD #_____VC_____

FAMILY PHYSICIAN:_____ OTHER HEALTHCARE _____

DIAGNOSIS / MEDICAL HISTORY: ☐ Chronic bronchitis ☐ Bronchiectasis ☐ Emphysema

☐ Bronchopulmonary dysplasia ☐ Cystic fibrosis ☐ COPD ☐ Interstitial lung disease

☐ Kyphoscoliosis ☐ Neuromuscular disease (specify)_____ ☐ OSAS ☐ CSAS

☐ Palliative (specify) _____

☐ Other diagnosis (specify) _____

COMPLICATIONS: ☐ Cor Pulmonale ☐ Pulmonary hypertension ☐ Secondary polycythemia _____HCT %

☐ **HOME OXYGEN ASSESMENT WITH ARTERIAL BLOOD GASES IF Sp02 is< 90%**

Arterial Blood gases are performed with a home oxygen assessment unless INR is >2.2
Please indicate below if ABGS are contraindicated

PATIENT IS ON ANTICOAGULANTS: ☐ YES ☐ NO If YES: PTT _____ (23-35 Seconds normal range)
INR _____ (0.7-1.3 normal range) Platelets: _____ (130-400 normal range)
PATIENT is **NOT** on a Thrombolytic Agent: ☐ _____

☐ **Oxygen prescription: _____LPM Titration order Sp02** ☐ **88 -92 %** ☐ **>92%**

☐ **Comfort Measures Unless specified otherwise, oxygen will be administered to maintain SpO2 of > 92%**

☐ Overnight oximetry

Referring Physician / NP Name (please spell) _____

Phone # _____ Fax # _____

Physician Signature / NP _____