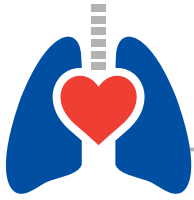


RESPIRATORY SERVICES REQUISITION



**LAKELAND
RESPIRATORY**
GROUP OF COMPANIES

6212 - 52 Avenue, Bonnyville, AB, Phone (780) 826-2507
1-800-668-5359 • www.lakelandrespiratory.ca
email: isleep@lakelandrespiratory.ca

NAME	:	
ADDRESS	:	
PHONE	:	ALTERNATE: _____
PHN	:	
DOB	:	
PHYSICIAN:	:	
PHYSICIAN'S PHONE:	:	FAX: _____
PHYSICIAN'S ADDRESS:	:	

RETURN BY FAX (780) 812-2545

Respiratory Homecare:

- Home Oxygen
- Assess / Reassess for Home O2 with required testing
- Aerosol Compressor
- Suction Therapy
- Other _____

Sleep Diagnostics:

- Level III Sleep Study for OSA - Interpreted
- CPAP Therapy _____ cm H₂O
- Auto CPAP Therapy _____ cm H₂O
- Bilevel Therapy Insp./Exp. _____ cm H₂O
- Other _____

Respiratory Diagnostics:

- Respiratory Assessment (may include all of the below)
- Pulmonary Function Study
* Unless specified 400mg MDI Salbutamol or 2.5mg Salbutamol neb will be used.
- Spirometry:
 - Please Check box if Beta 2 bronchodilator is contraindicated for your patient
- Oximetry
- Nocturnal Pulse Oximetry
- Exertional Walk Test
- Arterial Blood Gas
 - Room Air
 - Oxygen _____ Lpm
 - Home O₂ Reauthorization
- Other _____

Consultations (Letter Required):

- Respiriologist Consultation
- Pediatric Respirologist Consultation
- Allergist Consultation

Please provide a referral letter and pertinent patient medical history

Education / Rehabilitation:

- Asthma Education / Action Plan with Certified Respiratory Educator
- COPD Education / Action Plan with Certified Respiratory Educator
- Inhaler Technique Consultation with Certified Respiratory Educator
- Smoking Cessation with Certified Respiratory Educator
- Pulmonary Rehabilitation
- Other _____

Referred By: _____

Phone: _____ Fax: _____

Allergies: _____

Medications: _____

Smoking History: _____

Physician's Comment: _____

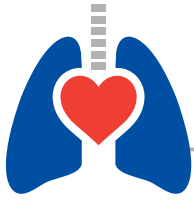
Diagnosis: _____

Physician's Signature _____ Date _____

Physician's PRACID # _____

If patient is unable to keep their appointment they should call our office as soon as possible. We request 24 hr notice if possible. If you need additional referral forms please call our office.

RESPIRATORY SERVICES REQUISITION



**LAKELAND
RESPIRATORY**

GROUP OF COMPANIES

Box 338, #11, 6109 - 50 Avenue,
Vegreville, AB T9C 1R3, Phone (780) 632-7611
1-800-668-5359 • www.lakelandrespiratory.ca
email: sales@lakelandrespiratory.ca

NAME	:	
ADDRESS	:	
PHONE	:	ALTERNATE: _____
PHN	:	
DOB	:	
PHYSICIAN:	:	
PHYSICIAN'S PHONE:	:	FAX: _____
PHYSICIAN'S ADDRESS:	:	

RETURN BY FAX (780) 632-7612

Respiratory Homecare:

- Home Oxygen
- Assess / Reassess for Home O2 with required testing
- Aerosol Compressor
- Suction Therapy
- Other _____

Sleep Diagnostics:

- Level III Sleep Study for OSA - Interpreted
- CPAP Therapy _____ cm H₂O
- Auto CPAP Therapy _____ cm H₂O
- Bilevel Therapy Insp./Exp. _____ cm H₂O
- Other _____

Respiratory Diagnostics:

- Respiratory Assessment
(may include all of the below)
- Pulmonary Function Study
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or 2.5mg Salbutamol neb will be used.
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 - Please Check box if Beta 2 bronchodilator
is contraindicated for your patient
- Oximetry
- Nocturnal Pulse Oximetry
- Exertional Walk Test
- Arterial Blood Gas
 - Room Air
 - Oxygen _____ Lpm
 - Home O₂ Reauthorization
- Other _____

Consultations (Letter Required):

- Respiriologist Consultation
- Pediatric Respirologist Consultation
- Allergist Consultation

Please provide a referral letter and pertinent patient medical history

Education / Rehabilitation:

- Asthma Education / Action Plan with Certified Respiratory Educator
- COPD Education / Action Plan with Certified Respiratory Educator
- Inhaler Technique Consultation with Certified Respiratory Educator
- Smoking Cessation with Certified Respiratory Educator
- Pulmonary Rehabilitation
- Other _____

Referred By: _____

Phone: _____ Fax: _____

Allergies: _____

Medications: _____

Smoking History: _____

Physician's Comment: _____

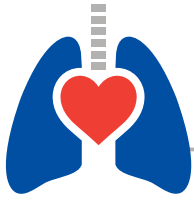
Diagnosis: _____

Physician's Signature _____ Date _____

Physician's PRACID # _____

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RESPIRATORY SERVICES REQUISITION



**LAKELAND
RESPIRATORY**
GROUP OF COMPANIES

6223 - 48 Ave., Camrose, AB, Phone (780) 672-1522
 1-800-668-5359 • www.lakelandrespiratory.ca
 email: julie@lakelandrespiratorycamrose.ca

NAME	:	
ADDRESS	:	
PHONE	:	ALTERNATE: _____
PHN	:	
DOB	:	
PHYSICIAN:	:	
PHYSICIAN'S PHONE:	:	FAX: _____
PHYSICIAN'S ADDRESS:	:	

RETURN BY FAX (780) 672-1524

Respiratory Homecare:

- Home Oxygen
- Assess / Reassess for Home O2 with required testing
- Aerosol Compressor
- Suction Therapy
- Other _____

Sleep Diagnostics:

- Level III Sleep Study for OSA - Interpreted
- CPAP Therapy _____ cm H₂O
- Auto CPAP Therapy _____ cm H₂O
- Bilevel Therapy Insp./Exp. _____ cm H₂O
- Other _____

Respiratory Diagnostics:

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- Arterial Blood Gas
 - Room Air
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 - Home O₂ Reauthorization
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- Inhaler Technique Consultation with Certified Respiratory Educator
- Smoking Cessation with Certified Respiratory Educator
- Pulmonary Rehabilitation
- Other _____

Referred By: _____

Phone: _____ Fax: _____

Allergies: _____

Medications: _____

Smoking History: _____

Physician's Comment: _____

Diagnosis: _____

Physician's Signature _____ Date _____

Physician's PRACID # _____

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