RESPIRATORY SERVICES REQUISITION

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 H_2O
- ☐ Auto CPAP Therapy __________ cm H_2O
- ☐ Bilevel Therapy Insp./Exp. __________ cm H_2O
- ☐ 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 O_2 Reauthorization
- ☐ Other

Consultations (Letter Required):

- ☐ Respirologist 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.