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 705.434.0084 | F: 705.434.0085 | TF: 1.855.440.3300  
 CompleteRespCare.com

**HOME OXYGEN**  
**Patient Referral Form**

Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

Hospital Staff Info: \_\_\_\_\_ (Name) \_\_\_\_\_ (Designation)

**Patient Personal Information**

(Phone)

(Ext)

Patient Name: \_\_\_\_\_

Health Card #: \_\_\_\_\_ (Version Code)

Patient Address: \_\_\_\_\_

Patient Tel: \_\_\_\_\_

Sex:  Male  Female

Patient Cell: \_\_\_\_\_

DOB (yyyy/mm/dd): \_\_\_\_\_

Next of Kin: \_\_\_\_\_

Next of Kin Tel: \_\_\_\_\_

**Patient Medical Details**

Diagnosis: \_\_\_\_\_

Qualification:

Oxygen Prescription:

Palliative

Oxygen Flow Rate (LPM) and Duration (hr)

Regular (Arterial Blood Gas Required)

|          | Rest | Exertion | Sleep |
|----------|------|----------|-------|
| Flow     |      |          |       |
| Duration |      |          |       |

Date Drawn (yyyy/mm/dd): \_\_\_\_\_

| pH | PaO <sub>2</sub> | PaCO <sub>2</sub> | SaO <sub>2</sub> |
|----|------------------|-------------------|------------------|
|    |                  |                   |                  |

Keep SpO<sub>2</sub> ≥ 90%

Exertional (Independent Exercise Assessment Required)

Keep SpO<sub>2</sub> 88% - 92%

IEA Date (yyyy/mm/dd): \_\_\_\_\_

Other: \_\_\_\_\_

IEA Faxed to the Vendor:  Yes  No

Other: \_\_\_\_\_

Tracheostomy Patient:  Yes  No

Comments: \_\_\_\_\_

**Referral Details**

Prescriber's Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please Fax Referral to 705-434-0085**  
**For After Hours On Call Service, Please Call 1.855.440.3300**



## **Home Oxygen Therapy Program Medical Eligibility Criteria**

### ***Long and Short Term Funding for Resting Hypoxemia:***

1. Resting ABG PaO<sub>2</sub> value ≤ 55 mmHg

*OR*

2. PaO<sub>2</sub> 56-60 mmHg accompanied by Cor pulmonale, Pulmonary Hypertension or persistent Erythrocytosis

*OR*

3. PaO<sub>2</sub> 56-60 mmHg with
  - a. Exercise limited Hypoxemia (SpO<sub>2</sub> ≤ 88% - Determined via Independent Exercise Assessment) or
  - b. Nocturnal Hypoxemia.

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### ***Long Term Funding for Exertional Hypoxemia:***

1. Resting ABG PaO<sub>2</sub> > 60 mmHg or Resting SpO<sub>2</sub> > 90%

*AND*

2. Exhibits exertional Hypoxemia (SpO<sub>2</sub> ≤ 88% - Determined via Independent Exercise Assessment).

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### ***Palliative Funding:***

1. Intended for individuals who are at the end stage of a terminal illness, receiving End of Life Care and required Home Oxygen Therapy.
2. Palliative applicants do not meet other Medical Eligibility Criteria (long term, short term or for exertional Hypoxemia).
3. Provides funding for maximum of 90 days (one funding period per lifetime).
4. No ABGs are required.