



6-355 Franktown Rd, Carleton Place, ON K7C 4M6  
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 CompleteRespCare.com

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

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

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

**Patient Personal Information**

Patient Name: _____	Health Card #: _____ <small style="float:right;">Version Code</small>
Patient Address: _____ _____	Patient Tel: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Cell: _____
DOB (yyyy/mm/dd): _____	Next of Kin: _____
	Next of Kin Tel: _____

**Patient Medical Details**

Diagnosis: _____ Oxygen Prescription: <input type="checkbox"/> Oxygen Flow Rate (LPM) and Duration (hr) <table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <tr> <td style="width:15%;"></td> <td style="width:20%;">Rest</td> <td style="width:20%;">Exertion</td> <td style="width:20%;">Sleep</td> </tr> <tr> <td>Flow</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Duration</td> <td></td> <td></td> <td></td> </tr> </table> <input type="checkbox"/> Keep SpO2 ≥ 90% <input type="checkbox"/> Keep SpO2 88% - 92% <input type="checkbox"/> Other: _____		Rest	Exertion	Sleep	Flow				Duration				Qualification: <input type="checkbox"/> Palliative <input type="checkbox"/> Regular (Arterial Blood Gas Required) <input type="checkbox"/> Exertional (Independent Exercise Assessment Required) <input type="checkbox"/> Home Oxygen Assessment <input type="checkbox"/> Other: _____ Arterial Blood Gas Results Date Drawn: _____ <table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <tr> <td style="width:25%;">pH</td> <td style="width:25%;">PaO<sub>2</sub></td> <td style="width:25%;">PaCO<sub>2</sub></td> <td style="width:25%;">SaO<sub>2</sub></td> </tr> </table> IEA Faxed to the Vendor: <input type="checkbox"/> Yes <input type="checkbox"/> No	pH	PaO <sub>2</sub>	PaCO <sub>2</sub>	SaO <sub>2</sub>
	Rest	Exertion	Sleep														
Flow																	
Duration																	
pH	PaO <sub>2</sub>	PaCO <sub>2</sub>	SaO <sub>2</sub>														
Tracheostomy Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____ _____																	

**Referral Details**

Referring MD/NP: _____	Tel: _____
Signature: _____	Fax: _____

**Please Fax Referral to 613-253-2050**



## **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.