



HOME LIFECARE SERVICES INC.

Sleep Apnea Therapy & Home Oxygen

PICKERING • TORONTO •

SCARBOROUGH

www.homelifecare.com

(416) 410-9550 • 1-888-219-0202

Fax 905-831-4847

Oxygen Referral Form

Client Data

Client name: _____
Health Card: _____
DOB: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Contact Phone: _____

Physician Data

Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____
Family Physician _____

Home Oxygen Assessment & Setup:

| | |
|--|--|
| Prescription: REST _____ LPM EXERTION _____ LPM SLEEP _____ LPM Diagnosis: _____ _____ | ABG information pH: _____ Date: _____ PaO2: _____ PCO2: _____ SaO2: _____ Palliative: <input type="checkbox"/> |
|--|--|

Overnight Oximetry Only:

Home Oxygen Assessment Only:

Our office will contact your patient to arrange an in-home assessment conducted by one of our Registered Healthcare Professional. The results will be forwarded to your office for review.

Ontario Home Oxygen Program Funding Criteria

- Resting Oxygen - PaO2 ≤55% or SpO2 ≤88% on room air at rest for 5 minutes
- Nocturnal Oxygen - SpO2 ≤88% for ≥ 30% of minimum 4 hour study
- Exertional Oxygen - SpO2, 88% for 2 minutes of a 6 minutes test on room air with exertion

Diagnosis: _____

Physician Comments: _____

Physician Signature: _____ Date: _____