RESPIRATORY THERAPY CARE CONSULTANTS

RtCC

REFERRAL FORM

Please fax form to:604-539-9099

☐ Check if you would like us to send you more referral forms.

Patient Name: _____

Patient Phone: _____

MSP#/DOB: _____

Height _____ **Weight** _____ **Gender** ☐ **M** ☐ **F**

History and Physical Information:

_____

_____

_____

Common OSA Symptoms

- ☐ Snoring
- ☐ Daytime fatigue
- ☐ Hypertension
- ☐ Dry Mouth
- ☐ Witnessed Apneas/Choking
- ☐ Morning Headaches
- ☐ Frequent Nocturia
- ☐ Poor judgement or concentration

Medical Conditions

- ☐ CHF
- ☐ Stroke
- ☐ MI/CAD
- ☐ GERD
- ☐ Asthma/COPD
- ☐ Cardiac Arrhythmia
- ☐ Diabetes
- ☐ Mood Disorder/Anxiety
- ☐ _____
- ☐ _____

1 ☐ Sleep Apnea Screening:

- ☐ **Overnight Oximetry on Room Air. (no fee applies)**
- ☐ **Level 3 Home Sleep Test. (fee applies)**
- ☐ **Request an interpretation of study by Specialist. (fee applies)**
- ☐ **Request consultation for diagnosis and management of Sleep Disorded Breathing by Respirologist.**

☐ Sleep Apnea Treatment:

Proceed with the following therapy after Positive Screen:

- ☐ **CPAP** _____ cmH2O
- ☐ **BiPAP** _____ cmH2O
- ☐ **CPAP and Mask consult (equipment fee applies)**
- ☐ **Heated humidity** ☐ **Chin Strap** ☐ **CPAP Pillow**

2 ☐ Home Oxygen Assessment:

- ☐ **Complete the following as required (fee applies):**
- ☐ **Resting oximetry.**
- ☐ **Exertional oximetry. (6 min walk test)**
- ☐ **Overnight Oximetry .**

☐ Home Oxygen Therapy:

- ☐ **Oxygen Concentrator** — **At Rest:** _____ **L/min**; **Nocturnal:** _____ **L/min**
- ☐ **Portable Oxygen Concentrator** — **Exertional:** _____ **L/min**

3 Other Please specify: _____

Ordering Physicians Name	Physicians Signature	Date
_____	_____	_____

Mailing Address Langley Clinic: #103-5503 206 St Langley, BC V3A 2C6

- **Phone: (604) 539-9098**
- **Web: www.breathebetter.ca**
- **Email: info@breathebetter.ca**