MD/NP Referral form

Maritime Respiratory Care

PEI 2-26174 Rt 2 Summerside, PE C1N 4J8
NB 6-230 Old Post Rd. Petitcodiac, NB E4Z 4P2

Patient Name:_____ **MRN or Medicare #**_____

Address:_____

Date of Birth:_____ **Phone #** _____

Patient Symptoms (check all that apply) ☐ **Hypertension** ☐ **Depression** ☐ **Snoring** ☐ **Witnessed Apneas**

☐ **Abrupt awakening/gasping** ☐ **Unable to stay asleep** ☐ **Daytime Fatigue** ☐ **Frequent Nocturnal Urination**

☐ **Morning Headache**

Please do: (Check all that apply)

Sleep apnea and oximetry

○ **Overnight oximetry on** _____**r/a or** ____ **lpm**

○ **Level III Sleep Study**

○ **CPAP/APAP Therapy if mild, moderate or severe OSA identified**

○ **CPAP therapy at** _____**cmH20**

○ **BiPAP therapy: Parameters**_____

Home O2

○ **Assess for Home O2**

○ **Home O2 at** ___ **lpm**

○ **Keep SpO2 ≥** _____**%** **-or-** ○ **Keep SpO2 between** ___**% and** ___**%**

○ **Other:** _____

Physician or NP _____ **Signature** _____