Lakeridge Health

Community Respiratory Services

CHANGING LIVES − *One breath at a time*

Home Oxygen Referral

Patient Name: _____ Date: _____

Date of Birth: _____ Phone Number: _____

Health Card #: _____

Address: _____

Diagnosis: ❒ COPD ❒ Chronic Bronchitis ❒ Bronchiectasis ❒ Emphysema ❒ Interstitial lung disease

❒ Other: _____

❒ Home Oxygen Assessment (order may include)

- ✓ Oximetry
- ✓ Exertional oximetry
- ✓ Arterial blood gases

Criteria: Home Oxygen Program Set−Up

- Applicants must have chronic hypoxemia on room air at rest (PaO2 of ≤ 55 mmHg)
- Applicants with a persistent PaO2 of 56−60 mmHg may be approved if the following medical conditions exist:
  - ➢ cor pulmonale
  - ➢ pulmonary hypertension
  - ➢ persistent erythrocytosis
  - ➢ exercise limited hypoxemia improved with supplemental oxygen

OR

❒ Palliative Home Oxygen Program Set−Up

- Requires Palliative Diagnosis (i.e. End−Stage Cancer, CHF, COPD)
- Automatic 3 month qualification
- Once per lifetime

❒ Home Oxygen Prescription: Rest _____ LPM Exertion ____ LPM Sleep ____ LPM

In the absence of an oxygen flow rate, the client will be set up on 2 LPM until an assessment by the Registered Respiratory Therapist can be completed. The results will be forwarded to your office for review.

Ordering MRP: _____ Signature: _____

NOTE: If sending a fax after 8:00 PM Monday−Friday or after 4:00 PM on Saturday and Sunday, please call the number below to notify us that the fax as been sent.

Please fax form to 905−721−4744

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