

Long term ventilation – Respiratory Support Clinic Referral Form

PLEASE FAX REFERRAL FORM TO 226-896-2030

Please call the Airway Clinic at 226-896-2026 if you have any questions or concerns

Patient Name: _____ HCN#: _____

Date of Birth: _____ Gender: Male Female

Parent Name (if applicable): _____

Address: _____

Phone (Home): _____ (Work): _____

Referring Physician/Nurse Practitioner: _____ CPSO #: _____

Family Physician (if different from referring provider) _____

- Reason for Referral:**
- Consultation only
 - Consultation and co-management
 - Consultation and assume care

Diagnosis

- Neuromuscular Disease** Specify: _____
- Skeletal Disorder (e.g. Kyphoscoliosis)** Specify: _____
- Obesity Hypoventilation**
- Overlap Syndrome (e.g. COPD+OSAS+/- Obesity)**
- Central Hypoventilation**

Previous History Information

- ABG's Results** pH_____ pCO₂_____ pO₂_____ HCO₃⁻_____ Base Excess_____ FIO₂
- Pulmonary Function Test** (please attach)
- CXR results** (please attach)
- Previous Consultations** (please attach)
- Medications:** _____

Specific Reason for Referral

- Invasive Ventilation
- Non Invasive Ventilation
- Lung Volume Recruitment
- Non-Invasive Secretion Clearance
- Tracheostomy change/management
- Other: _____

Signature of Referring Provider: _____ Date: _____

Provider Address: _____

Provider Phone number: _____ Fax number: _____

Airway Clinic Response: Please notify your patient an appointment has been scheduled for:

Date: _____

Time: _____

