Canadian Home Healthcare Inc.

OSHAWA • TORONTO • NORTH YORK • MISSISSAUGA • OAKVILLE • HAMILTON • KITCHENER
TEL: 1-800-268-5003 • FAX: 1-888-848-4451 • E-MAIL: INFO@CANADIANHOMEHEALTHCARE.CA

HOME OXYGEN REFERRAL

Please fill in all information and email or fax to our office. Patients will be contacted directly.

Client Data

Last: ______________________________

First: ______________________________

D.O.B: ________________ ☐ Male ☐ Female

Health Card No: ______________ VC: ______

Address: ______________________________

________________ Postal Code: ________

Phone: (H) (_____)__________ (C): (_____)__________

E-mail: ______________________________

Contact Person: ______________________________

Contact Phone: ______________________________

Referring Physician Information

Name: ______________________________

OHIP Billing No: ______________________________

Address: ______________________________

____

Phone: (_____)______________________________

Fax: (_____)______________________________

Family Physician (if different from above): ________________

Signature: ________________ Date: ________

Home Oxygen Assessment Only ☐

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

Ontario Home Oxygen Program Funding Criteria

- *Resting Oxygen – $PaO_2 \leq 55$ mmHg or PaO_2 56-60 mmHg accompanied with nocturnal or exertional desaturation of $\leq 88\%$*
- *Exertional Oxygen – IEA required from an Independent Health Facility (CHH will request a referral if required)*

Diagnosis: ______________________________

Communicable Disease: ______________________________

Physician Comments:

Home Oxygen Assessment & Set-up ☐

Prescription: ______________ ***lpm 24 hrs*** or

______________ ***lpm prn or***

______________ ***lpm nocturnal***

Diagnosis: ______________________________

Communicable Disease: ______________________________

ABG Information:

ABG's ph: ______________ Date: ______________

PaO_2: ______________

PCO_2: ______________

SaO_2: ______________

Palliative ☐

- In the absence of an oxygen flow rate, the client will be set at 2 lpm until an assessment has been conducted by one of our Registered Healthcare Professionals. Assessments are arranged within one business day. The results will be forwarded to your office for review.

Physician Comments: