PROVINCIAL RESPIRATORY OUTREACH PROGRAM

PRESCRIPTION FOR SERVICES

PLEASE FAX TO: 604-326-0176 **QUESTIONS: 1-866-326-1245**

CLIENT INFORMATION:

FIRST NAME:	LAST NAME:
DATE OF BIRTH:	PHONE NUMBER:
ADDRESS:	
	POSTAL CODE:
FUNDING AGENCY (IF APPLICABLE)	

CLINICAL ASSESSMENT:

CLINICAL ASSESSMENT ATTACHED (INCLUDE REASONING FOR HOME VENTILATION): ☐

DIAGNOSIS:			
SECONDARY DIAGNOSIS:			
MEDICAL HISTORY:			
VITAL CAPACITY (L. and % pred) :	Date:	ABG'S	Date:

EQUIPMENT REQUIREMENTS

☐ BILEVEL:

SPONTANEOUS: YES ☐ NO ☐		SPONTANEOUS/TIMED: YES ☐ NO ☐
IPAP: cm/H_2O	EPAP: cm/H_2O	RESPIRATORY RATE:
INTERFACE: MAKE & SIZE:		

☐ VOLUME VENTILATOR:

MODE:	VOLUME:	I:E / % /Ti	
RESPIRATORY RATE:	PRESSURE:	VENT ALARM:	WAVE FORM:
LOW PRESSURE:	HIGH PRESSSURE:	SENSITIVITY B/E:	PRESSURE CONTROL:
TRACHEOSTOMY TUBE: MAKE & SIZE:			
CUFFED: ☐ CUFFLESS: ☐	FENESTRATED: YES ☐ NO ☐	OTHER:	
INTERFACE: MAKE & SIZE:			
SUPP. O_2 :	HAVE ARRANGEMENTS BEEN MADE WITH OXYGEN SUPPLIER? YES ☐ NO ☐		

I authorize the addition of the following treatment modalities as required:

☐ ORAL SUCTION DEVICE ☐ MANUAL COUGH ASSIST ☐ AEROSOL COMPRESSOR

AUTHORIZATION:

NAME OF RESPIROLOGIST:	
PHONE NUMBER:	FAX NUMBER:
RESPIROLOGIST'S SIGNATURE:	DATE: