COMPLETE
HEALTHCARE SOLUTIONS
LIVE LIFE WELL

2123 Algonquin Avenue, North Bay, ON P1B 4Z3 • Tel: 705-474-5600 • ***Fax To: 705-474-5859***

PATIENT REFERRAL FORM

Patient Name: ______________________________

Gender: **Male:** ___ **Female:** ___

Patient Address: ______________________________

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Telephone #: ______________________________

Health Card #: ______________________________

Date of Birth: ______________________________

Comments: ______________________________

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Date: ______________________________

Physician Name: ______________________________

Address: ______________________________

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Telephone #: ______________________________

Fax #: ______________________________

Diagnosis: ______________________________

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HOME OXYGEN

- ☐ Home Oxygen Assessment
  (oximetry and/or Arterial Blood Gases if required)
- ☐ Palliative Home Oxygen Set Up

SLEEP THERAPY

- ☐ Sleep Apnea (pre-screening)
- ☐ CPAP Trial*
- ☐ CPAP/BIPAP Set Up*
- ☐ Auto CPAP Trial*
  *(*initial diagnostic study required)*

Physician's/Nurse Practitioner's Signature: ______________________________

CONSIDERED A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN/NURSE PRACTITIONER

(Service Bilingue)