Halifax
7071 Bayers Rd, Unit 140
Fax: 902-455-9373 • Ph: 902-455-5163

Stellarton
91 Lawrence Blvd. Unit 1D
Fax: 902-755-6106 • Ph:902-755-5671

Dartmouth
650 Portland St., Unit 115A
Fax: 902-450-0075 • Ph: 902-435-0957

Sydney
200 Churchill Dr. Suite 105
Fax: 902-539-5156 • Ph: 902-539-7351

Addressograph

HOME RESPIRATORY REFERRAL

Phone 1-833-904-2473 • www.vitalaire.ca

Patient information

Last Name: First Name: ☐ Male ☐ Female

Address:

City: Postal Code: DOB: MM/DD/YY

Home Phone: Cell Phone: Health Insurance #:

Alternate Contact Name: Contact Phone:

Diagnosis:

Sleep Apnea Assessment

Refer for assessment if 3 or more boxes are checked

SYMPTOMS / COMORBIDITIES

- ☐ Loud disruptive snoring
- ☐ Witnessed Apneas
- ☐ Excessive daytime sleepiness
- ☐ Wake up unrefreshed / excessive daytime fatigue
- ☐ Large neck size (>17” in men OR >16” in women)
- ☐ BMI > 30

PAST MEDICAL HISTORY

- ☐ Hypertension
- ☐ Diabetes
- ☐ Metabolic Syndrome
- ☐ Arrhythmias, CAD, Hx CVA
- ☐ Coronary Artery Disease
- ☐ Cardivascular Disease
- ☐ COPD
- ☐ Anxiety/Depression

Sleep Apnea Diagnostics and Treatment

REFERRAL:

Please check **one** of the following:

- ☐ Level 3 Sleep Study with APAP/CPAP trial/treatment
- ☐ CPAP/APAP Therapy ☐ Bi level ☐ A Servo-Ventilation
- ☐ Consultation with Dr. Gosia Phillips, Sleep Medical Specialist

COPD Screener:

Refer for assessment if 1 or more boxes are checked

	YES	NO
1. Do you cough up phlegm regularly?	☐	☐
2. Do even simple chores make you short of breath?	☐	☐
3. Do you wheeze when you exert yourself (exercise, go up stairs?)	☐	☐
4. Are you a smoker or ex-smoker?	☐	☐
5. Are you older than 40 years old?	☐	☐
6. Have you ever had a respiratory related hospital admission?	☐	☐

Diagnosis:

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Home Oxygen Referral:

- ☐ Oxygen Assessment
- ☐ Humidified High Flow Therapy
- ☐ Overnight Oximetry
- ☐ OPEP Therapy

Home Oxygen Rx

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Special Instructions

Clinic Stamp

☐ I have obtained written consent from the patient agreeing to the collection, use and disclosure of his/her information to VitalAire Canada Inc.

Physician/Professional Name: ______________________ Date: MM / DD / YYYY

Signature: ______________________ Phone: ______________ Fax: ______________

Our referral form can be found on all Nova Scotia EMR platforms

Fax to 1-866-489-0202