LHR
London Home Respiratory

Physician Referral Form

Patient Information

Health Card Number:	Date of Birth:
Last Name:	First Name:
Phone Number:	Address:
City:	Postal Code:

Treatment

Home Oxygen

- ☐ Assessment
- ☐ Set Up
- ☐ Flow @ _____ lpm
- ☐ SaO_2 > 92%
- ☐ With Exertion
- ☐ Nocturnally
- ☐ Palliative

Medical Devices

- ☐ Aerosol Compressor
- ☐ CPAP _____ cm H_20
- ☐ Suction Equipment
- ☐ Aerochamber/MDI

Services

- ☐ PFT
- ☐ Nocturnal Oximetry
- ☐ Sleep Apnea Screening
- ☐
- ☐

Requisitioning Physician / Practitioner

Physician / Practitioner Number:

Patient Diagnosis

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Cor Pulmonale
- ☐ CHF
- ☐ Pulmonary Fibrosis
- ☐ CA _____

Other / Comments:

Physician Signature

Signature

Date

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