Canadian Home Healthcare Inc.

OSHAWA • TORONTO • NORTH YORK • MISSISSAUGA • OAKVILLE • HAMILTON • KITCHENER
TEL: 1-800-268-5003 • FAX: 1-888-848-4451 • E-MAIL: REFERRALS@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 ≤ 55 mmHg or PaO_2 56-60 mmHg accompanied with nocturnal or exertional desaturation of ≤ 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: