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

CPAP REQUISITION

Please fill in all information and email or fax to our office. Patients will be contacted directly.

1. Client Data

Last: _____

First: _____

D.O.B: _____ ☐ Male ☐ Female

Health Card No: _____ VC: _____

Address: _____

_____ Postal Code: _____

Phone (H): (_____)_____ (C): (_____)_____

E-mail: _____

2. Referring Physician Information

Name: _____

Address: _____

_____

Phone: (_____)_____

Fax: (_____)_____

Clinic Name: _____

ADP Clinic No: _____

Signature: _____ Date: _____

4. Request For

☐ PAP Therapy

1. ☐ CPAP ☐ APAP ☐ BiLevel ☐ ASV ☐ Other:_____
2. ☐ Trial ☐ Purchase
3. Pressure (cmH_2O): _____, Ramp (Optional): _____
4. Machine Type (Optional): _____, Mask (Optional): _____
5. AHI (Optional): _____
6. Other Settings (Optional):

☐ Additional Services

1. ☐ Pressure Change (cmH_2O): _____
2. ☐ In-Home Set-up
3. ☐ Overnight Oximetry
4. ☐ Compliance Data
5. ☐ Other: _____

4. Additional Comments / Notes: