CLINIQUE INHALO

Services Ambulants d'Inhalothérapeute

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Patient Referral Form

Patient: ______________________________

Address: ______________________________

City: ______________ Postal Code: ______________

Phone: ______________ Cell: ______________

Date of Birth: ______________ RAMQ: ______________ Female ☐ Male ☐

(month/day/year)

Sleep Apnea Assessment

☐ **In-Home Sleep Apnea Evaluation**

☐ If AHI ≥10 proceed to CPAP Titration with pressure 5-15 CmH2o.

☐ **CPAP/Bi-Level Titration** *Forward previous test/screening results with referral*

CPAP or Mask Reassessment

Medical Hx: *The following comorbidities increase the prevalence of Sleep Apnea. Check all that apply:*

Condition	Prevalence of OSA	Condition	Prevalence of OSA
☐ Drug Resistant Hypertension	83%	☐ Atrial Fibrillation	49%
☐ BMI >30	77%	☐ Diabetes	48%
☐ Congestive Heart Failure	76%	☐ Cardiac Disease	30%
☐ Pacemakers	59%	☐ COPD or Other ______	

Respiratory Assessment

☐ **Respiratory Assessment and/or Oxygen Therapy**

Report includes resting, walking, overnight oximetry, auscultation and health history

Oxygen R_x: ______________________________

Medical H_x: ______________________________

Spirometry

☐ **Pre/Post Spirometry with Bronchodilator**

☐ **Flow Volume Loop**

Referring Physician: ______________________

(print)

Referring Clinic Phone: ______________ **Fax:** ______________

Family Physician: *(If different than referring)* ______________ **Date:** ________

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