ISLAND RESPIRATORY SPECIALISTS
IRS

Charlottetown: 902-892-2828
Summerside: 902-436-9633

Please Fax: 1-888-794-7979
or Email: office@irspei.ca

Referral Form

Patient Information: (please print)

Name: _____

D.O.B. _____ **PHN:** _____
m / d / y

Address: _____

Phone: _____ **Cell:** _____

Email: _____

Diagnosis:

- ☐ COPD
- ☐ Diabetes
- ☐ Asthma
- ☐ Cardiac Disease
- ☐ Hypertension
- ☐ Arrhythmia
- ☐ Cancer
- ☐ ILD
- ☐ Other: _____

Referring Physician & License #: _____
(Please Print)

Referring Clinic Phone #: _____

Sleep Therapy

- ☐ **Level IV - Nocturnal Oximetry – HR/Sp02**
  - ☐ Sleep Apnea Screening – no interpretation
  - ☐ COPD/CHF overnight assessment
- ☐ **Level III - Home Sleep Diagnostic Test for OSA – HR/Sp02/Effort/Nasal Flow/Position**
- ☐ **Proceed to PAP Therapy Trial**
  (OSA Diagnosis confirmed Moderate to Severe)
  - ☐ Auto CPAP Trial – 1 month free trial
  - ☐ Auto BiPAP Trial
  - ☐ Other _____

Oxygen Therapy:

- ☐ **Oxygen Assessment**
  (Includes Resting/Walking Oximetry & Respiratory Assessment)
- ☐ **Home Oxygen Therapy:**
  - ☐ Oxygen Concentrator ___ l/min
  - ☐ Portability ___ l/min
  - ☐ Usage ___ hrs/day

Physician's Signature: _____

Date: _____