HOMESTEAD
OXYGEN + MEDICAL EQUIPMENT

10 Moose Road
Lindsay, ON.
K9V 6K8

(p) 705.328.3015
(tf) 1.800.990.8873
(f) 705.328.0166

www.homesteadoxygen.ca

RESPIRATORY REQUEST FORM

Patient Information

Name: _____
Address: _____
City: _____
Phone: _____
D.O.B: _____/_____/_____
H.C#: _____

Request From

Dr. _____
Address: _____
City: _____
Phone: _____
Fax: _____

Patient Diagnosis: _____

OXYGEN SET UP THROUGH MOH

[QUALIFYING ABG'S OR IEA REQUIRED]

☐ Home Oxygen @ _____ lpm

Please include ABG or IEA results if applicable

@ rest _____ hours/day
exertion _____ hours/day
sleep _____ hours/day

PALLIATIVE OXYGEN SET UP

[NO MEDICAL CRITERIA REQUIRED]

☐ Palliative Home Oxygen @ _____ lpm _____ hours/day

90 days palliative coverage only available once per lifetime

OXYGEN SET UP

PATIENT PAY/INSURANCE
[DOES NOT MEET MOH CRITERIA]

☐ Concentrator @ _____ lpm _____ hours/day

☐ Cylinder Oxygen *(FOR PRN USE ONLY)* @ _____ lpm _____ hours/day

RESPIRATORY/OXYGEN ASSESSMENT

☐ Oxygen Oximetry Assessment at rest and on exertion (if possible)

☐ Overnight Oximetry On Room Air _____ On Oxygen @ _____ lpm

_____ PHYSICIAN (PRINT)

_____ PHYSICIAN SIGNATURE

_____ DATE

CPSO # _____ BILLING # _____

THIS WILL BE RECOGNIZED AS A VALID PRESCRIPTION WHEN SIGNED BY PHYSICIAN.