OTTAWA COMMUNITY LUNG HEALTH PROGRAM

Suite 200 2249 Carling Ave.
Ottawa ON K2B 7E9
tel: (613) 288-0163

Complex Respiratory Care Program

Referral Form

Fax to 613-288-0022 Phone 613-288-0163

Date: *(yyyy/mm/dd)*

Client Information

Last Name:_____ First Name:_____
Gender: □ M □ F □ Other DOB: *(yyyy/mm/dd)*
Address: _____
Phone: _____Email: _____
Health Card Number: _____

Primary Diagnosis:

Allergies:

Most Responsible Physician:_____Phone:_____
Fax:_____

Respirologist:_____Phone:_____
Fax:_____

Primary Contact Information (if other than client):
Name:_____Relationship to client:_____
Phone: _____

Referral Information

Referring Facility:
□ TRC □ Montfort
□ TOH-General □ QCH
□ TOH-Civic □ Home and Community Care-LHIN
□ CCC □ Nursing Agency (specify)_____
□ Other (specify)_____

Referral source contact information:
Name:_____Title:_____
Phone:_____Fax:_____

Reason for Referral:
□ Discharge from hospital to home
□ Education for client, caregiver, or health provider
□ Staff education - Agency/Organization:_____
□ Routine tracheostomy tube change at home
□ Consultation (specify):_____
□ Other:_____

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Current Respiratory Care Needs
□ BiLevel – Non-Invasive ventilation BiLevel Model:_____ Start Date: *(yyyy/mm/dd)* How many hours per day is the client using Bilevel:_____ Parameters: _____
□ CPAP CPAP Model:_____ Start Date: *(yyyy/dd/mm)*
□ Invasive Ventilation Ventilator Model:_____ Start Date: *(yyyy/dd/mm)* How many hours per day is the client using mechanical ventilation?_____ Parameters:_____
□ Tracheostomy Trach tube brand:_____ □ Cuffed □ Uncuffed Cuff volume/pressure_____ Humidification type_____ □ Speaking Valve □ Cork Date of recent trach tube change: *(yyyy/mm/dd)* Frequency of trach changes:_____ Trach changes performed by: _____ Comments:_____
□ Suctioning □ Oral □ Tracheal Frequency of tracheal suctioning in 24hrs:_____
□ Cough Assist Parameters:_____Frequency:_____ Performed by:_____
□ Lung Volume Recruitment: Frequency:_____Performed by:_____
□ Oxygen Therapy □ Nasal Prongs □ Mask □ Tracheal Flow/Fi02:_____
□ High Flow Heated Humidity (AIRVO) □ Trach □ Nasal Prongs Parameters:_____
□ Other_____ _____
Documentation Faxed with Referral Form
□ Past Medical History □ Relevant Consultation Notes □ Discharge Summary □ Medications