
FreshAir Respiratory Care Inc.

Home Oxygen Therapy/Sleep Apnea/Pulmonary Diagnostics Referral Form

Patient Information or Patient Label

First Name: _____ PHN#: _____
Last Name: _____ Address: _____
Sex: M __ F __ | Date of Birth: _____
Phone Number: (Primary) _____ Phone: (Other) _____
Email: _____ Preferred Method of Contact: _____

Diagnosis: _____

Medical History/Notes:

- Home Oxygen Assessment (ABG/PFT as required)
- Sleep Apnea Diagnostic Testing (To include CPAP treatment if required)
- Complete Pulmonary Function Test
- Arterial Blood Gas (ABG)
- AADL Walk Test
- Pulmonary Consult

Referring Physician/Practitioner Information or Clinic Stamp and Signature

Name: _____ Fax Number: _____

Signature: _____ Phone Number: _____

Date: _____ Clinic: _____

Physician Practice I.D.: _____

Stamp: