CareicaHealth OXYGEN

Toll Free: 1-855-672-6262
Fax: 204-822-3852

Oxygen Referral Form – NIHB/Other

Date ____ DD ____ MM ____ YY

Please be advised that the client has met eligibility for the following program:

☐ NIHB ☐ PCDAP ☐ Private ☐ Other _____

Client information

MB Health # _____ PHIN _____ Treaty # _____

Name (Last, First) _____

Address _____ Phone Number _____

Postal Code _____ Birthdate (D/M/Y) ____ / ____ / ____ Sex _____

Client's Physician _____ Phone Number _____

Hospital / Location _____ Phone Number _____

Hospital Contact _____ Phone Number _____

Hospital RRT _____ Phone Number _____

Oxygen prescription

(Please attach a copy of the prescription indicating litre flow & hours of use / day)

☐ O_2 Continuous at _____ LPM.
☐ O_2 at Rest _____ LPM.
☐ O_2 at Night _____ LPM.
☐ O_2 with Exercise at _____ LPM.
☐ O_2 PRN at _____ LPM.
☐ O_2 with CPAP / BiPAP _____ LPM.

Respiratory Diagnosis _____

Has "In Hospital" Training Been Completed? ☐ Y ☐ N ☐ Unsure

Mental status

☐ Alert ☐ Confused ☐ Oriented ☐ Cognitively Impaired ☐ Anxious ☐ Nervous

Mobility

☐ Independent Uses Aides: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Other _____

Home / dwelling

☐ Apartment ☐ *Elevator* ☐ *(or) Stairs* ☐ House ☐ *Bungalow* ☐ *(or) 2-Storey*

Are there safety concerns in the client's home? ☐ Y ☐ N If Yes, _____

Primary support

☐ Self (If self, do not fill out additional information)

☐ Spouse ☐ Child ☐ Friend ☐ Relative Name _____ Phone _____
☐ Child ☐ Friend ☐ Relative Name _____ Phone _____

Does the client speak English? ☐ Y ☐ N Do the client's support person(s) speak English? ☐ Y ☐ N _____

Authorized Referrer (Print) _____ Signature _____ Phone _____

Case Coordinator (Print) _____ Signature _____ Phone _____