INDEPENDENT RESPIRATORY SERVICES

Phone: 1.877.965.6204
Fax: 1.866.888.6011
Email: referrals@irscanada.ca
Web: www.irscanada.ca

Preferred Vendor for Fraser Health, Providence Health Care & Vancouver Coastal Health Authority

Patient Referral Form

Patient: _____
(first name) *(last name)*

Address: _____

City: _____ **Postal Code:** _____

Phone: _____ **Cell:** _____

Date of Birth: _____ **PHN:** _____ Female ☐ Male ☐
(month/day/year)

Sleep Apnea Assessment

☐ **In-Home Sleep Apnea Evaluation**
☐ If **POSITIVE** proceed to CPAP Titration

☐ **CPAP/Bi-Level Titration** *Forward previous test/screening results with referral*

☐ **CPAP or Mask Reassessment**

Medical H_X: *The following comorbidities increase the prevalence of Sleep Apnea. Check all that apply:*

	Prevalence of OSA		Prevalence of OSA
☐ Drug Resistant Hypertension	83%	☐ Atrial Fibrillation	49%
☐ BMI >30	77%	☐ Diabetes	48%
☐ Congestive Heart Failure	76%	☐ Cardiac Disease	30%
☐ Pacemakers	59%	☐ COPD or Other	_____

Respiratory Assessment

☐ **Oxygen Therapy and/or Respiratory Assessment**
Report includes resting, walking, overnight oximetry, auscultation and health history

Oxygen R_X: _____

Medical H_X: _____

Referring Physician: _____ _____ Submit to Referrals _____
(print) *(signature)*

Referring Clinic Phone: _____ **Fax:** _____

Family Physician: *(If different than referring)* _____ **Date:** _____

☐ *Check box if you require additional referral pads*

*** *Many Extended Health Benefit Providers, Provincial and Federal Agencies provide funding for respiratory equipment. Our respiratory therapy, education and support services are provided free of charge to IRS patients.* ***BC MSP*** *does NOT fund respiratory equipment and services.*

REV: February 5, 2018