ADVANCED RESPIRATORY CARE NETWORK

Patient Information

Label Here

Referring Physician

Date:

Referring Clinic:

Physician Name:

Physician Address:

Physician Fax:

Physician Phone: Prac ID:

Physician Signature:

Considered a valid prescription when signed by a physician

Copies to:

Is this an Urgent Request? ☐ Yes ☐ No

Is Patient Aware of Referral? ☐ Yes ☐ No

CENTRAL ALBERTA LOCATIONS

RED DEER
#135, 4309 - 52 Avenue
Red Deer, Alberta T4N 6S4
T 403.342.0494
F 403.343.0304

WETASKIWIN
5217D - 50 Street
Wetaskiwin, Alberta T9A 3B8
T 780.312.7502
F 780.666.9722

CAMROSE
#31, 6601 - 48 Avenue
(Inside Duggan Mall)
Camrose, Alberta T4V 3G8
T 780.673.1150
F 780.666.9722

AIRDRIE
East Airdrie Medical Clinic
#103, 188 Market Street
Airdrie, Alberta T4A 0K9
T 403.873.0891
F 403.735.5163

CALGARY NE
#201, 3151 - 27 Street NE
Calgary, Alberta T1Y 0B4
T 403.235.4109
F 403.235.4147

SHERWOOD PARK (Head Office)
80 Sioux Road
Sherwood Park, Alberta T8A 3X5
T 780.449.1434
F 780.449.1435

Sleep Therapy

Clinical History:

☐ Snoring ☐ Witnessed Apnea
☐ Hypertension ☐ Diabetes
☐ Asthma/COPD ☐ Gasping

Reason for Referral _____

_____

Neck Circumference _____ (cm)

Sleep Study:

☐ Level III Sleep Study *(no fee)*
If positive for sleep apnea per physician interpretation, initiate auto CPAP

☐ Level I Sleep Study (Polysomnography)
(fee may be applicable)

☐ Auto CPAP Therapy
_____cm H_20 to _____ cm H_20

☐ CPAP Therapy _____ cm H_20

☐ BiPAP Therapy

Mode: AVAPS_____ ST_____ Auto SV_____

IPAP_____ EPAP_____ RR_____ Ti_____

☐ Level III Sleep Study Only *(no fee)*

Otolaryngology (ENT)

- Only available in Red Deer -

☐ Otolaryngology Consultation

Indications:

☐ Otitis Media ☐ Oral Cavity Lesion
☐ Hearing Loss ☐ Hoarseness
☐ Vertigo ☐ Dysphagia
☐ Sleep Apnea ☐ Neck Mass
☐ Epistaxis ☐ Tonsilitis
☐ Rhinosinusitis / Nasal Obstruction
☐ Other *(please specify):*_____

Respiratory

☐ Adult Pulmonary Consult
☐ Adult Internal Medicine Consult

Pulmonary Function Testing:

☐ Full Pulmonary Function
☐ Pre-Post Spirometry

Respiratory Assessment:

☐ Assessment for Home Oxygen
☐ Nocturnal Oximetry *(fee applicable)*
☐ Extertional Oximetry
☐ Arterial Blood Gas

Home Oxygen Therapy:

☐ Keep $Sp0_2$ >89% or >_____ %
_____ Lpm x _____ hr/day

☐ Home Oxygen Assessment - AADL Protocol

Home Respiratory Equipment:

☐ High Flow Humidity
☐ Suction Setup
☐ Nebulizer Setup

Allergy

- Only available in Red Deer -

☐ Allergy Consult and Testing *(tray fee applicable)*

☐ Consult only ☐ Cough
☐ Allergy Rhinitis ☐ Wheezing
☐ Allergies, unspecified ☐ Asthma
☐ Atopic Dermatitis ☐ Hives
☐ Other: *(please specify)* ☐ Immunotherapy

Adult Cardiology

☐ Holter Monitoring
☐ ECG (Electrocardiogram)
☐ 24 Hour Blood Pressure Monitor

CLINICAL NOTES:_____

Revision Date: 19/08/2025