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

SOUTHERN ALBERTA LOCATIONS

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

CALGARY NW
#3130, 11 Royal Vista Drive NW
(Inside Medicare Clinic Royal Oak)
Calgary, Alberta T3R 0N2
T 403.873.0891
F 403.735.5163

CALGARY SE
Sunpark Professional Centre
#225, 40 Sunpark Plaza SE
Calgary, Alberta T2X 3X7
T 403.873.0891
F 403.873.1817

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

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

Sleep Therapy

Clinical History:

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

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/Adjusted 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)*

Allergy

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

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

_____

Adult Cardiology

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

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)*
☐ Exertional 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

Otolaryngology (ENT)

☐ Rhinology Consultation

Indications:

☐ Rhinosinusitis / Nasal Obstruction
☐ Chronic Sinusitis and Post-Nasal Drip
☐ Nasal Allergies (sneezing, runny nose, itchy eyes, etc.)
☐ Nasal Congestion ☐ Nasal Blockage
☐ Foul-smelling Nasal Discharge ☐ Nasal Polyps
☐ Chronic or Recurring Sinus Pain
☐ Sinus Infections
☐ Loss of Smell
☐ Other *(please specify)*: _____

CLINICAL NOTES: _____

Revision Date: 19/08/2025