

Referral for Respiratory Therapy

Contact the Home and Community Care Support Services HNHB at 1-800-810-0000

Patient Name _____ HCN _____ VC _____ DOB _____
Address _____ City _____ Province _____ Postal Code _____
Patient Phone _____ Contact Name _____ Contact Phone _____
Preferred Language _____

Tube Information

Tracheostomy Tube Type (brand) _____ Size _____
 Uncuffed Cuffed → Cuff Volume _____ mL of Air OR Sterile Water
 No Inner Cannula OR Inner Cannula → Size _____ and Disposable OR Reusable
Type of Trach Ties _____
 Laryngectomy Tube Type (brand) _____ Size _____
Tracheal T-Tube (brand) _____ Size _____

Follow-up

Post Discharge Follow-up established with _____ Phone # _____
(i.e., Outpatient ENT, Respiriologist)

Care and Tube Change (ADP application for trach tube / supplies required by Homecare Vendor)

Specialized Stoma Dressings → _____

Specialized Stoma Care Routines → _____

Tube Change Frequency _____ (recommend monthly) Being Changed By _____

Suction and Supplies (ADP application for equipment / supplies required by Homecare Vendor)

Portable Suction and Supplies _____ Suction Catheter Size _____

Humidification (ADP application for equipment / supplies required by Homecare Vendor)

Heat Moisture Exchange Heat Moisture Exchange with Oxygen Cold Aerosol Heated Humidity
 Specific Day & Night Routine _____

Speaking Valves and / or Caps (ADP application for supplies required by Homecare Vendor)

Speaking Valve Cork / Cap
 Specific Day & Night Routine _____

Vendor Contact for Trach / Laryngectomy Tube Supplies / Suction / Humidification / Speaking Valves

Vendor Name _____ Phone # _____
Fax # _____ ADP Application to Vendor Via _____

Patient Name _____ HCN _____ VC _____ DOB _____

Oxygen (ADP application for Oxygen and supplies requires completion)

- Oxygen Interface _____ FiO2 _____ % Set Flow to _____ Lpm
- Flow of _____ Lpm via Nasal Prongs while using Cork / Cap Flow of _____ Lpm to Speaking Valve Interface
- Specific Day & Night Routine _____

ADP application for Oxygen in the Home completed by _____

Home Oxygen Vendor _____

ADP application to Vendor via _____

Lung Volume Augmentation

- Breath Stacking Frequency → _____ and PRN Abdominal Thrusts: Yes No As Needed

Mechanical Ventilation / BPAP Spontaneous Timed / Mechanical In-Exsufflation / Cough Assist Therapy

- Ventilator Equipment & Supplies (ADP application required for equipment & supplies)

Ventilator model _____ Circuit Type _____

Ventilator Settings during the Day: Mode _____ Volume _____ mL OR Insp Pressure _____ cmH2O

Rate _____ bpm PEEP _____ cmH2O Oxygen _____ Lpm Pressure Support _____ cmH2O

Ventilator Settings at Night: Mode _____ Volume _____ mL OR Insp Pressure _____ cmH2O

Rate _____ bpm PEEP _____ cmH2O Oxygen _____ Lpm Pressure Support _____ cmH2O

Other specific Day and Night Ventilator Routine _____

- BPAP ST and Supplies (ADP application required for equipment and supplies)

BPAP ST Model _____ Mask Type _____ Mask Size _____

BPAP ST Settings during the Day: Mode _____ Insp Pressure _____ cmH2O Exp Pressure _____ cmH2O

Rate _____ bpm Oxygen Flow: _____ Lpm Other: _____

BPAP ST Settings at Night: Mode: _____ Insp Pressure: _____ cmH2O Exp Pressure: _____ cmH2O

Rate _____ bpm Oxygen Flow _____ Lpm Other: _____

Other specific Day and Night BPAP ST Routine _____

- Mechanical In-Exsufflation and supplies (ADP application required for equipment and supplies)

Mode _____ Insp Time _____ sec. Exp Time: _____ sec. Pause Time _____ sec.

Insp Pressure _____ cmH2O Exp Pressure _____ cmH2O Frequency _____

Other specific settings _____

Abdominal Thrusts: Yes No As needed

ADP application Ventilator Equipment and Supplies completed by: _____

****Portable Suction & Emergency supplies for any accidental trach tube obstruction / decannulation are to be immediately available at all times, including during any transfers (Tracheostomy Bag or Kit)****

Referral Information

Respiratory Therapist Name _____ Phone _____

Pager _____ Primary Care Practitioner _____

CPSO / CNO # _____ Date (dd/mm/yyyy) _____

Prescriber Name _____ Signature _____