Centre for Pulmonary Rehabilitation

"Investing back in our Community"

At "**The Village**" 100 College Drive, North Bay, ON P1B 8K9
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E: info@pulmonaryrehab.ca | www.pulmonaryrehab.ca

PRESCRIPTION FORM
Fax to:
705-840-2857

Prescribing Physician: _____

Phone: _____ **Faxed to CPR by:** _____

Patient Name: _____ Phone: _____ D.O.B: YY / MM / DD

Street Address: _____ Postal Code: _____

Health Card #: _____ Version Code: _____

Diagnoses: _____

_____

Rx:

Home Oxygen Therapy

- ☐ O2 @_____ lpm at rest
- ☐ O2 @_____ lpm on exertion
- ☐ O2 @_____ lpm during sleep

Chronic ABG results

Ph_____ **PaC02**_____ **Pa02**_____ **Sa02**_____

- ☐ **In-home ABG testing**
- ☐ Palliative (clients are covered once in a lifetime)
- ☐ Nocturnal Oximetry
- ☐ In-Home Pulmonary Rehab Asessment
  *For CPR Oxygen Clients only

Sleep Therapy

- ☐ **Auto-PAP trial**
  Unless indicated, will be set to 6/16 with cellular modem. One month free trial. Set final pressure to 90% of optimal observed pressures)
  other:

- ☐ CPAP therapy
  _____ cmH20

- ☐ Bi-level therapy:
  IPAP _____ cmH20
  EPAP _____ cmH20

Special Instructions: _____

_____

_____

_____

Doctor's Name: _____ (Please Print) Billing #: _____

Signature: _____ Date: YY / MM / DD