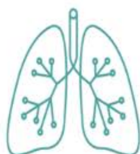

ROSEMOUNT BRANCH
30 ROSEMOUNT AVE.
OTTAWA, ONTARIO K1Y 1P4

TEL: (613) 288-0163
WWW.SWCHC.ON.CA

PROGRAM OF SOMERSET WEST COMMUNITY HEALTH CENTRE

Complex Respiratory Needs Referral Form

Fax to 613-288-0022 Phone 613-288-0163

Date: *(yyyy/mm/dd)*

Client Information

Last Name: ___________________ First Name:___________________

Gender: □ M □ F □ Other DOB: *(yyyy/mm/dd)*

Address: ____

Phone: ____________________________

Primary Diagnosis:

Allergies:

Most Responsible Physician: __________________ Phone:______________________________

Fax:______________________________

Respirologist:_____________________ Phone:______________________________

Fax:______________________________

Primary Contact Information (if other than client):

Name:____________________________ Relationship to client:________________

Phone: ___________________________

Referral Information

Referring Facility:

□ TRC
□ TOH-General
□ TOH-Civic
□ CCC
□ Montfort
□ QCH
□ Home and Community Care-LHIN
□ Nursing Agency (specify)_______
□ Other (specify)____

Referral source contact information:

Name:_________________________ Title:__________________________________

Phone:_________________________

Reason for Referral:

□ Discharge from hospital to home
□ Education for client, caregiver, or health provider
□ Staff education - Agency/Organization:_________________________________
□ Routine tracheostomy tube change at home
□ Consultation (specify):____
□ Other:____

ROSEMOUNT BRANCH
30 ROSEMOUNT AVE.
OTTAWA, ONTARIO K1Y 1P4
PROGRAM OF SOMERSET WEST COMMUNITY HEALTH CENTRE

TEL: (613) 288-0163
WWW.SWCHC.ON.CA

Current Respiratory Care Needs
□ BiLevel – Non-Invasive ventilation BiLevel Model:_______________ Start Date: *(yyyy/mm/dd)* How many hours per day is the client using Bilevel:______________________ Parameters: ____
□ CPAP CPAP Model:_________________ Start Date: *(yyyy/dd/mm)*
□ Invasive Ventilation Ventilator Model: ______________ Start Date: *(yyyy/dd/mm)* How many hours per day is the client using mechanical ventilation?_______ Parameters:____
□ Tracheostomy Trach tube brand:_____________ □ Cuffed □ Uncuffed Cuff volume/pressure__________ Humidification type________________ □ Speaking Valve □ Cork Date of recent trach tube change: *(yyyy/mm/dd)* Frequency of trach changes:___________________________ Trach changes performed by: __________________________ Comments:____
□ Suctioning □ Oral □ Tracheal Frequency of tracheal suctioning in 24hrs:______________________________
□ Cough Assist Parameters:_______________________ Frequency:____________________ Performed by:_____________________
□ Lung Volume Recruitment: Frequency:______________________ Performed by:____________________
□ Oxygen Therapy □ Nasal Prongs □ Mask □ Tracheal Flow/Fi02:_____
□ High Flow Heated Humidity (AIRVO) □ Trach □ Nasal Prongs Parameters:____
□ Other____ ____

Documentation Faxed with Referral Form
□ Past Medical History □ Relevant Consultation Notes □ Discharge Summary □ Medications