Ontario Health atHome

Referral for Respiratory Therapy

Contact the Ontario Health atHome 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, Respirologist)

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 _____

Print Clear

Version **21-001**

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)

Respiratory Therapist Name _____ Phone _____

Pager _____ Primary Care Practitioner _____

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

Prescriber Name _____ Signature _____