MagGas Medical Inc.

154 Norfinch Drive, Unit #1, Toronto, Ontario, M3N 1X6
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HOME OXYGEN THERAPY REQUISITION OF SERVICES

FAX TO: (416) 650 - 9443

PATIENT INFORMATION *(PLEASE PRINT)*		
Last Name	First Name	Sex ☐M ☐F
Address		
City	Province	Postal Code
Home Tel #	Work Tel #	
Health Card #	Date of Birth	

Home Oxygen Assessment

☐ Perform oximetry testing as per funding guidelines: this may involve oximetry at rest. Exertion and/or Sleep, on room air

☐ Perform oximetry testing to verify that the oxygen prescription meets the patients needs at rest, exertion and/or Sleep

☐ Perform room air arterial blood gas (ABG) to confirm funding eligibility

Oxygen Therapy Start

☐ Initiate Home Oxygen Therapy	REST:	LPM	HOURS/DAY
	Exertion:	LPM	HOURS/DAY
	SLEEP:	LPM	HOURS/DAY

PALLIATIVE OXYGEN THERAPY START

☐ Initiate Palliative Home Oxygen Therapy	LPM	HOURS/DAY

Comments:

Physician Name _____

Physician Signature _____ **Date** _____