MAGGAS MEDICAL INC.
Helping you breathe deep and rest easy.

Niagara Falls Location
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HOME OXYGEN THERAPY REQUISITION OF SERVICES

Patient Information (Please Print):

Last Name	First Name	Sex M☐ F☐ Date of Birth
Address	City	ON Postal Code
Health Card #	Home Tel #	Other Tel #
Diagnosis	Next of Kin Name	Next of Kin Tel #

Respiratory / 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 need at red,exertion and/or Sleep

☐ Other (Specify): _____

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

☐ MagGas Pulmmonary Wellness Program (COPD Management)

Chronic / Acute:

☐ Initiate Home Oxygen Therapy

REST	LPM	HOURS/DAY
EXERTION	LPM	HOURS/DAY
SLEEP	LPM	HOURS/DAY

OR

Maintain SpO2 > 88% or between

_____ - _____ %

Palliative:

☐ Initiate Palliative Home Oxygen Therapy

LPM HOURS/DAY

Arterial Blood Gas & Oximetry Result on Room Air:

Date:

Result: pH: PaC02: Pa02: HC03: Sa02:

Oximetry Sa02: REST: EXERTION: SLEEP:

CPAP/APAP/BiPAP Therapy:

Pressure: cmh20

Comments:

Other Respiratory Equipment:

☐ Medication Compressors ☐ AirVo2 /Humidity Therapy

☐ Suction Units ☐ APAP

☐ Cough Assist ☐ BiPAP

Comments / Instructions: _____

_____

☐ Physician ☐ Nurse Practitioner

Prescriber Name: _____ **Date:** _____ **Billing #** _____

Prescriber Signature: _____ **Telephone #** _____