Saskatchewan Health Authority

Respiratory Support Referral

Fax: 306-766-6049
Email: provincialcopdreferral@saskhealthauthority.ca

INITIAL APPLICABLE BOXES

☐ Not for central program distribution ☐ Patient is aware of referral

☐ Postal Code Verified _____ ☐ Client Phone number: _____

Respiratory History:

Reason for Referral: ☐ Suspected COPD ☐ COPD confirmed on Spirometry

Other Respiratory Conditions: ☐ Asthma ☐ Interstitial Lung Disease ☐ Other: _____

☐ Referral from hospital - Expected Discharge Date: _____

☐ Request Virtual follow-up service within 48 hours

☐ Post Discharge Follow-up Visit Required ☐ Palliative care for end-of-life care and service

Current oxygen usage: _____ Oxygen Provider: _____

Outpatient Respirologist: _____

Coordination of Care:

Does client have mobility issues: ☐ No

☐ Yes - describe: _____

Does client meet criteria for support with transportation (*unable to drive, no family member to support travel, unable to access public transit, not ambulatory*): ☐ Yes ☐ No

Does client require interpretation support? ☐ Yes ☐ No

Services Requested: (select as many as needed)

☐ Full Certified Respiratory Educator Support (included all 3 below)

- ☐ Commercial Tobacco Cessation Support
- ☐ Action Plan
- ☐ Education, including inhaler technique

☐ Pulmonary Rehab Program **(must attach spirometry tests)**

☐ Referral to Outpatient Dietitian

Comments: _____

_____

_____

Section above completed by (Printed Name and designation): _____

Signature: _____ Date: _____

PRACTITIONER SIGNATURE REQUIRED for Immunizations, Home Oxygen Testing, and/or Pulmonary Testing

Immunizations – if applicable follow the Anaphylaxis Identification and Initial Treatment [Clinical Procedure] (CS-CP-0015)

☐ Influenza Vaccine 0.5 mL IM

☐ COVID Vaccine

☐ Pneu-C-20 Vaccine (PREVNAR 20™) 0.5 mL IM x 1 dose as per SIM Chapter 10 Pneu-C-20 Vaccine Pages.

☐ Pneu-C-21 Vaccine (CAPVAXIVE®) 0.5 mL IM x 1 dose as per SIM Chapter 10 Pneu-C-21 Vaccine pages.

☐ Vaccines as required with signature on page 2

Saskatchewan Health Authority

Respiratory Support Referral

Fax: 306-766-6049
Email: provincialcopdreferral@saskhealthauthority.ca

INITIAL APPLICABLE BOXES

Home Oxygen Testing

Coverage:
☐ NIHB ☐ SAIL
☐ AADL (Alberta)

Does this client have Cor Pulmonale or Polycythemia? ☐ Yes ☐ No

☐ Initial Oxygen Assessment* (ABG performed only if deemed necessary by tester)

*If client doesn't qualify for continuous:

☐ Proceed with exertional testing and nocturnal testing ☐ Proceed with exertional testing ONLY

☐ Oxygen Renewal Assessment (ABG performed only if deemed necessary by tester)

☐ Continuous ☐ Exertional ☐ Nocturnal

☐ SAIL/NIHB renewal date (if known): _____

☐ Arterial Blood Gas (ABG) ☐ on Room Air ☐ on O_2 _____L/Min

Reason for testing: _____

☐ Nocturnal Oximetry Test (per SAIL/NIHB Criteria)

☐ On room air only or ☐ On O_2_____ L/Minute

☐ On CPAP: Current settings: _____ ☐ On BiPAP: Current settings: _____

☐ On Oxygen: Current settings:_____

Pulmonary Testing

Indication for testing: _____

☐ Spirometry (testing includes 4 puffs salbutamol) – CS-PIER-0342 Getting Ready for your Spirometry Test

☐ Full Pulmonary Function Test (spiro/lung volumes/diffusion capacity) – includes 4 puffs Salbutamol

☐ Other: (please explain) _____

Respirologist only to order: ☐ Methacholine Challenge ☐ 6-Minute Walk Test

Respirologist/ Neurologist/Rheumatologist only to order: ☐ MIP/MEP ☐ Upright + Supine Spirometry

Comments:_____

_____

_____

_____

Relevant History/Contraindications to spirometry

☐ Hemoptysis of unknown origin	☐ Thoracic or abdominal surgery (past 4 weeks)	☐ Confusion/ Dementia
☐ Recent pneumothorax (past 2 weeks)		☐ Infection Control Issue
☐ Aneurysms (thoracic, abdominal, cerebral)	☐ Pulmonary embolism	☐ MI (within 1 week)
	☐ Unstable Angina	☐ Shunt
☐ Recent eye surgery (past 1 week)	☐ Severe hypertension	☐ Allergy to Bronchodilators
☐ Other:		

Referring Provider (print): _____ Date: _____

Practitioner Signature: _____ Date: _____

Copies to: _____