Home Oxygen
RESPIRATORY CARE GROUP

PCH Request For Home Oxygen Services

Fax 1-204-822-3852 | Phone 1-888-297-7889

Addressograph | Patient Information

Service Requested ☐ Installation ☐ Removal Date Requested ______ / ______ / ______
DD MM YY

Prescription (Please Attach if Available)

☐ O_2 Continuous at ____________ LPM.
☐ O_2 With Exercise at ____________ LPM.
☐ O_2 at Rest ____________ LPM.
☐ O_2 PRN at ____________ LPM.
☐ O_2 at Night ____________ LPM.
☐ O_2 with CPAP / BiPAP ____________ LPM.

Diagnosis ________________________________

Special Notes (Please Add any Additional Information of Value such as Medications, Communicable Diseases, etc.)

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Authorization (By Facility Coordinator or Client Care Coordinator)

Name ____________________
Facility ____________________
Signature ____________________
Phone ____________ Fax ____________

Removal of Equipment (Complete this Section Once Equipment is No Longer Needed)

☐ Oxygen Equipment Removal
Reason for Removal ____________________
Requested By ____________________
Date Requested ______ / ______ / ______
DD MM YY

OE 4.04