RANA

Respiratory Wellness Centre

Order Authorization

TRES Program

Please review the recommendation(s) below. If you agree with the recommendation(s), please sign, date and fax back to RANA. *IMPORTANT* RANA takes patient privacy seriously, please include a blank fax cover sheet that does not contain any patient information.

To: RANA Respiratory Wellness Centre **Date of Order:** _____ / _____ /_____ (DD / MM / YYYY)

ATTN: Michelle Moroz, Client Services Coordinator

Fax: (204) 725-3339 **Questions? 1 (855) 774-6156**

Subject: Respiratory Equipment/Supplies Order **Total Page(s):**

From: RHA _____ **District Office** _____

Received From: ◯ **Hospital | In-Patient** ◯ **Hospital | Emergency** ◯ **Doctor's Office** ◯ **Home Care**

Order Placed By: _____ **Date Order Required By:** _____ / _____ /_____ (DD / MM / YYYY)

Phone Number: _____

Comments: _____

_____

Order Recipient

Name _____ PHIN (9-digit) _____ MHSC (6-digit) _____

Phone _____ Gender ◯ Male ◯ Female ◯ Identifies as _____

Address _____ DOB _____ / _____ / _____ (DD / MM / YYYY)

_____

Support Person _____ Phone _____ Relationship _____

Client's Doctor _____ Phone _____ Fax _____

Client's Diagnosis _____

Equipment & Supplies ☐ **Required** ☐ **Removed** **(include Serial Number(s): _____, _____)**

CODE	EQUIPMENT DESCRIPTION	QTY	SUPPLIES DESCRIPTION	QTY
C-1	20 PSI Compressor		Mask: ◯ Adult ◯ Pediatric **OR** ◯ Pipe Kit	
C-2	50 PSI Compressor		Mask: ◯ Adult ◯ Pediatric **OR** Trach: ◯ Adult ◯ Pediatric	
S-1	Suction Unit		◯ Yankaeur **OR** ◯ Catheters (check size below) ◯ 8 ◯ 10 ◯ 12 ◯ 14 ◯ 16 ◯ 18	
S-2	Portable Suction Unit		◯ Yankaeur **OR** ◯ Catheters (check size below) ◯ 8 ◯ 10 ◯ 12 ◯ 14 ◯ 16 ◯ 18	

RANA Office Use Only: Client Number _____

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