CareicaHealth

Allied Health Referral Request

TRES Program

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

To: Careica Health

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 ☐ M ☐ F ☐ 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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