

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: M	lichelle Moroz, Client Services Coo	dinato	r				
Fax: (20	4) 725-3339 Questions? 1 (855	774-6	3156				
Subject: Respiratory Equipment/Supplies Order				Total Page(s):			
From: RI	НА		District Office	<u> </u>			
Received From: Hospital In-Patient Hospit			oital Emergency Doctor's Office Home Care				
Order Placed By: Do			ate Order Required By:/				
Phone N	lumber:						
Commer	nts:						
Order R	recipient recipient						
Name			PH	PHIN (9-digit) MHSC (6-digit)			
Phone			Ge	nder M	F Identifies as		
Address			DC	DB/	_/		
Support Person ————				Phone Relationship			
Client's Doctor			Ph	Phone Fax			
Client's D	Diagnosis						
Equipme	ent & Supplies Required		Removed (ir	nclude Serial Number(s):,)	
CODE	EQUIPMENT DESCRIPTION	QTY		SUPPLIES DES	CRIPTION	QTY	
C-1	20 PSI Compressor		Mask: Adu	ılt Pediatric OR	Pipe Kit		
C-2	50 PSI Compressor		Mask: Adu	ılt Pediatric OR	Trach: Adult Pedi	iatric	
S-1	Suction Unit		Yankaeur (OR Catheters (ch 8 10 12 1			
S-2	Portable Suction Unit		Yankaeur (OR Catheters (ch 8 10 12 1			

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Careica Office Use Only: Client Number _