



Leave the rest to us!

Sleep Apnea Clinic / Pulmonary Function Lab - Physician Referral Form

Patient Information

Name: _____ Male Female
Date Of Birth (MM/DD/YY): _____ Health Care Number: _____
Day time Phone: () Evening Phone: () Cell Phone: ()

Physician Referral Information

Physician Name: _____
Address: _____
City: _____ Postal Code: _____
Phone: () Fax: ()

If two or more of the following symptoms are applicable, there is a strong possibility that Sleep Apnea may be the cause.

- S - Snoring
- L - Lack of energy
- E - Excessive daytime sleepiness
- E - Episodes of gasping or choking during sleep
- P - Persistent morning headaches

Obstructive Sleep Apnea Assessment and Treatment Includes:

- Level III Sleep Study interpreted by a Pulmonary/Sleep Specialist
- CPAP Titration
- *Results to be forwarded to referring physician*

Pulmonary Function Testing (*Leduc Site Only*):

- Spirometry*
- Full PFT*

*if possible, patient should avoid taking any short-acting bronchodilators for 4 hours prior to testing
ie: *Atrovent, Bricanyl, Ventolin*

*if possible, patient should avoid taking any long-acting bronchodilators for 12 hours prior to testing
ie: *Advair, Oxeze, Serevent, Spiriva, Symbicort*

Date (MM/DD/YY): _____ Physicians Signature: _____