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: ( ) Cell Phone: ( )

Physician Referral Information

Physician Name: Prac. ID:

Address:

City: Province: 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 engery
- ◯ **E** - Excessive daytime sleepiness
- ◯ **E** - Episodes of gasping or choking during sleep
- ◯ **P** - Persistent morning headaches
- ◯ **Cardiac History:** ______
- ◯ **History of Lung Disease :** ______

Obstructive Sleep Apnea Assessment and Treatment Includes (please check):

- ☐ Level III Sleep Study interpreted by a Pulmonary/Sleep Specialist
- ☐ CPAP Titration and/or discontinue treatment 1- 2 nights for Retesting
- ● *Results to be forwarded to referring phyisician*

Pulmonary Function Testing

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

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

Physician Comments/Reason for Referral

______

______

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

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#108, 6209-50 Street, Leduc, AB T9E 7A9

St. Albert 780.459.9239 Fax 780.459.9256
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sleepFX.ca