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*

Physician Comments/Reason for Referral

____

____

____

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

***St. Albert* 780.459.9239 Fax 780.459.9256**
#7, 44 St. Thomas Street, St. Albert, AB T8N 6N8

FULLY ACCREDITED CPSA

sleepFX.ca