

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 energy
- 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:

- Level III Sleep Study interpreted by a Pulmonary/Sleep Specialist
- CPAP Titration if positive for OSA and recommended by Sleep Specialist
- *Results to be forwarded to referring physician*

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: