sleepFX
APNEA TESTING + TREATMENT

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:

- 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 phyiscian*

Physician Comments/Reason for Referral

_____

_____

_____

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

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#7, 44 St. Thomas Street, St. Albert, AB T8N 6N8

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