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 and/or discontinue treatment 1- 2 nights for Retesting
- *Results to be forwarded to referring phyiscian*

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

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