ACCREDITED HSAT FACILITY ACCREDITED

# 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*

## 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