

Patient Demographics (please print or attach label)

PHN: _____ Date of Birth: _____ Sex: M F Other
 Last Name: _____ First Name: _____
 Address: _____ City: _____ Postal Code: _____
 Home Phone #: _____ Cell Phone #: _____

Assessment/Diagnostics

- Sleep Apnea Testing/Treatment (Level III Sleep Study (HSAT), CPAP/AutoCPAP Treatment)
- Level III Sleep Study (HSAT) Only
- Overnight oximetry on CPAP Therapy

Therapies

- AutoCPAP Therapy ____cmH2O to ____cmH2O
- Fixed CPAP Therapy ____cmH2O

Health History

- Congestive heart failure
- Chronic opioid use
- Neuromuscular disease
- Asthma/ COPD
- Oxygen use

Reason for Referral

- Snoring
- Daytime sleepiness
- Witnessed apneas
- Gasping or choking at night
- Family history of sleep apnea
- Other: _____

Physician Signature:

Referring Physician:

PRAC ID:

Date of Referral:

Physician Signature:

Physician Phone #:

Physician Fax #:

Thank you for your referral.
Please fax the completed form to 825-203-8411.

Sleep Well Diagnostics Ltd.

P: 825-203-5190

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