SLEEPWELL
DIAGNOSTICS LTD

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

Therapies

- ☐ AutoCPAP Therapy ____cmH20 to____cmH20
- ☐ Fixed CPAP Therapy ____cmH20

Physician Signature

Referring Physician:_____
PRAC ID:_____
Date of Referral:_____
Physician Signature:_____
Physician Phone #:_____
Physician Fax #:_____

Reason for Referral

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

Thank you for your referral. **Please fax completed form to [fax number].**

Sleep Well Diagnostics Ltd.
[Phone Number]
[Fax Number]
[Email Address]
[Address]