

Physician Fax #:

**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 #:

\_\_\_\_\_

Thank you for your referral.

**Please fax the completed form to 825-203-8411.**

**Sleep Well Diagnostics Ltd.**

P: 825-203-5190

Info@SleepWellAB.com

#302 9821 108St

Fort Saskatchewan, AB

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