CareicaHealth

Referral Form

FAX #'s: See page 2

PATIENT NAME AND INFORMATION

(Please complete or affix patient label)

DATE ____ DD ____ MM ____ YY

Patient Name _____

Street Address _____

City/Town _____

Postal Code _____

Daytime Phone _____

Email _____
(For appointment scheduling use only)

Date of Birth ____ DD ____ MM ____ YY Sex ☐ M ☐ F ☐ Identifies as: _____

PHN(s) _____

SLEEP SERVICES

☐ Sleep Apnea Diagnostics (Level III) & Treatment as Required
Level III sleep study, consultation, APAP therapy (4/20cm$H_2$0)* as recommended.
*Pressures and mode adjusted as required to optimize therapy.

☐ Level III Sleep Study Only

☐ APAP Trial & Treatment (4/20cm$H_2$0)*
Sleep-Disordered Breathing/OSA diagnosis must have been established in the last 12 months. A level III sleep study will be repeated if required.
*Pressures and mode adjusted as required to optimize therapy.

☐ APAP/CPAP Re-Assessment (4/20cm$H_2$0)*
May include overnight oximetry. Please include previous sleep study results if done elsewhere. A level III sleep study will be repeated if required.
*Pressures and mode adjusted as required to optimize therapy.

OXYGEN SERVICES

☐ Home Oxygen Assessment
Maintain SpO2 ›89%, PFT and/or ABG, Level III sleep study, per provincial guidelines.

PULMONARY FUNCTION SERVICES

(CALGARY/AIRDRIE ONLY)

☐ Complete Pulmonary Function Test

☐ Spirometry

☐ Arterial Blood Gas (ABG)
☐ PaO2 ‹60mmHg start O2 therapy

☐ Methacholine Testing*

☐ Respirology Consult*

REASON FOR TESTING

☐ Query/Evaluate Asthma

☐ Query/Evaluate COPD

☐ Other: _____

*A recent PFT is required by the Respirologist (within 6 months). If no recent PFT included, then complete test will be performed.

PATIENT MEDICAL INFORMATION

(AS REQUIRED)

☐ Significant cardiopulmonary disease (e.g. heart failure, severe COPD)

☐ Respiratory muscle weakness due to neuromuscular conditions

☐ Previous Sleep Disorder Diagnosis: _____

☐ Chronic opioid medication use

☐ History of stroke

Other (e.g. medication and conditions): _____

REFERRING PHYSICIAN AUTHORIZATION

(Please complete or affix clinic label)

Physician Name _____

Practice ID _____

Clinic Name _____

Address _____

Phone _____

Fax _____

Signature _____

Stop Bang Screening Tool[1]

Y	N	
Y	N	Do you snore loudly? Louder than talking, or to be heard through closed doors?
Y	N	Do you often feel tired, fatigued, or sleepy during the daytime?
Y	N	Has anyone observed you stop breathing during your sleep?
Y	N	Do you have, or are you being treated for high blood pressure?
Y	N	Is your BMI greater than 35?
Y	N	Are you over 50 years old?
Y	N	Is your neck circumference > 41 cm (women) or > 43 cm (men)?
Y	N	Are you male?

Score
(total number of "Yes" answers)

RISK OF OSA

Low:
Yes to 0-2 questions

Intermediate:
Yes to 3-4 questions

High:
Yes to 5-8 questions

[1] Chung F et al J Clin. Sleep Med. Sept 2014.
http://www.stopbang.ca/osa/screening.php

FAX #'s:

BRITISH COLUMBIA

Burnaby
Fax: 604-291-6939

Victoria
Fax: 250-370-9365

ALBERTA

Airdrie/Calgary
Fax: 403-250-3055

Edmonton/ Lloydminster
Fax: 780-498-2729

Red Deer
Fax: 403-346-0427

SASKATCHEWAN

Estevan
Fax: 306-636-2728

Moose Jaw
Fax: 306-693-2700

North Battleford
Fax: 306-937-7764

Prince Albert
Fax: 306-764-1271

Regina
Fax: 306-790-1305

Saskatoon
Fax: 306-651-0359

Swift Current
Fax: 306-773-3003

MANITOBA

Brandon
Fax: 204-725-3339

Winnipeg
Fax: 204-489-1336

PHONE # ALL LOCATIONS: TOLL FREE: 1-888-297-7889

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CareicaHealth.com