CareicaHealth

VICTORIA
3595 Ravine Way
Victoria, BC V8X 4Z1
FAX: 250-370-9365
PH: 250-370-9332

Referral Form

PATIENT NAME AND INFORMATION

(Please complete or affix patient label)

DATE ____ DD ____ MM ____ YY

Patient Name _____ Daytime Phone _____

Street Address _____ Email _____

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

Postal Code _____ PHN(s) _____

SLEEP SERVICES

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

☐ PAP_____ cmH2O

☐ Insomnia Cognitive Behaviour Therapy (CBT-I)*
*Provided by professional partners.

☐ Registered Dietitian Counselling*
*Provided by professional partners.

☐ Oral Appliance Therapy (OAT)*
*Provided by professional partners.

PATIENT MEDICAL INFORMATION

(AS REQUIRED)

☐ Previous Sleep Disorder Diagnosis: _____

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

REFERRING PHYSICIAN AUTHORIZATION

(Please complete or affix clinic label)

Physician Name _____ Address _____

Practice ID _____ Phone _____

Clinic Name _____ Fax _____

Signature _____