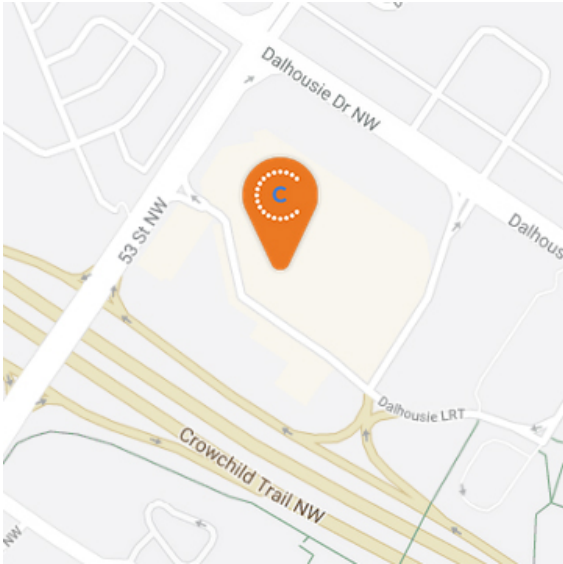


Date (DD/MM/YYYY)
/ /

Referral Form

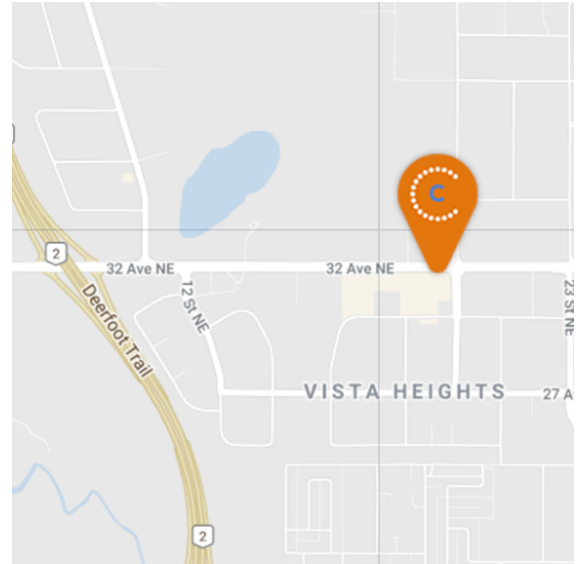
PATIENT INFORMATION			
Patient Name		Email	
Address		DOB (DD/MM/YYYY) / /	
City/Town	Province	<input type="checkbox"/> Male <input type="checkbox"/> Female	Identifies as _____
Postal Code	Phone	PHN	
SLEEP APNEA SERVICES		OTHER SERVICES	
<input type="checkbox"/> Sleep Apnea Diagnostics & Treatment (18yrs +) Level 3 home sleep apnea test (HSAT). May include sleep medicine consultation, PAP treatment, OAT – as recommended.		Provided by professional partners.	
<input type="checkbox"/> Level 3 Sleep Study Only		<input type="checkbox"/> Insomnia Cognitive Behaviour Therapy (CBT-I) If probable OSA, HSAT required.	
<input type="checkbox"/> PAP Trial, Treatment or Reassessment Prior diagnosis required. May include HSAT.		<input type="checkbox"/> Registered Dietitian Counselling	
<input type="checkbox"/> Oral Appliance Therapy (OAT) (Provided by professional partners.) Prior diagnosis required. May include HSAT and sleep medicine consultation – as recommended.			
PATIENT MEDICAL INFORMATION			
<input type="checkbox"/> Significant cardiopulmonary disease (e.g. heart failure, severe COPD)		<input type="checkbox"/> History of stroke	
<input type="checkbox"/> Respiratory muscle weakness due to neuromuscular conditions		<input type="checkbox"/> Chronic opioid medication use	
Reason for referral or previous sleep disorder diagnosis			
Other (e.g. medication and conditions)			
PULMONARY FUNCTION			
<input type="checkbox"/> Complete Pulmonary Function Test (PFT)		Reason for Testing:	
<input type="checkbox"/> Spirometry		<input type="checkbox"/> Cough	
<input type="checkbox"/> Arterial Blood Gas (ABG) <input type="checkbox"/> <i>PaO₂ < 60 mmHg start O₂ therapy</i>		<input type="checkbox"/> Query/evaluate Asthma	
<input type="checkbox"/> Methacholine testing*		<input type="checkbox"/> Query/evaluate COPD	
<input type="checkbox"/> Respiratory consult*		<input type="checkbox"/> Other: _____	
*A recent PFT is required by the respirologist. If no recent PFT (within 6 months) then complete test will be performed			
OXYGEN			
<input type="checkbox"/> Home oxygen assessment & treatment as required ABG and/or PFT will be completed per provincial guidelines. If oxygen therapy indicated, oxygen will be initiated to maintain SpO ₂ > 89%.			
PHYSICIAN INFORMATION			
Physician Name		Clinic Name	
Address		Practice ID#	
City/Town		Phone	Fax
Province	Postal Code	Physician Signature	

Calgary sleep clinics



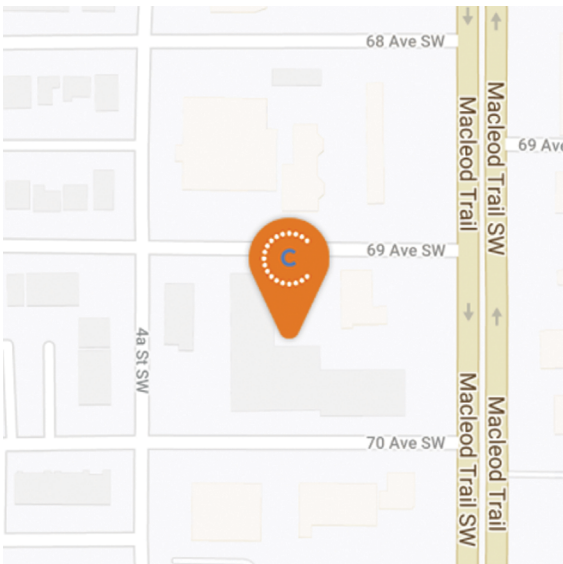
DALHOUSIE STATION

5005 Dalhousie Drive NW, Unit 161
Calgary, AB T3A 5R8



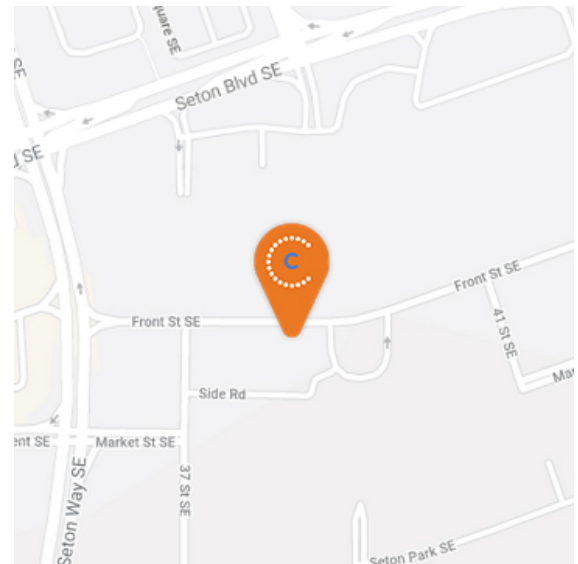
AIRWAYS BUSINESS PLAZA

1935 32nd Ave NE, Unit 130
Calgary, AB T2E 7C8



CENTRE 70 BUILDING

7015 Macleod Trail SW, Suite 115
Calgary, AB T2H 2K6



SETON PROFESSIONAL CENTRE

3883 Front Street SE, Suite 104
Calgary, AB T3M 2J6