

Referral Form

PATIENT INFORMATION			
Patient Name		Email	
Address		DOB (DD/MM/YYYY) / /	
City/Town	Province	☐ Male ☐ Female Identifies as _____	
Postal Code	Phone	PHN(s)	
SLEEP APNEA SERVICES		OTHER SERVICES	
Please note: patients must be 18+ for sleep testing. ☐ Level 3 Sleep Apnea Diagnostics & Treatment as Required Level 3 home sleep apnea test (HSAT). Consultation, PAP therapy (4/20 cm H₂O)* as recommended. <i>*Pressures and mode adjustment as required to optimize therapy.</i> ☐ PAP Trial, Treatment or Reassessment Prior diagnosis required. May include HSAT and consultation. PAP therapy (4/20 cm H₂O)* as recommended. <i>*Pressures and mode adjustment as required to optimize therapy.</i>		☐ Cognitive Behaviour Therapy for Insomnia (CBT-I) If probable OSA, sleep study recommended. ☐ Oral Appliance Therapy (OAT) Prior diagnosis or sleep study required. ☐ Registered Dietitian Counselling	
PATIENT MEDICAL INFORMATION			
☐ Significant cardiopulmonary disease (e.g. heart failure, severe COPD) ☐ Respiratory muscle weakness due to neuromuscular conditions		☐ History of stroke ☐ Chronic opioid medication use	
Reason for referral or previous sleep disorder diagnosis			
Other (e.g. medication and conditions)			
PRIVATE OXYGEN SERVICES O ₂ FAX #: 1-204-822-3852			
For publicly funded oxygen services, please refer to: https://gov.mb.ca/health/homecare/forms/hocp_fp.pdf			
O ₂ Continuous (LPM)	O ₂ at Rest (LPM)	O ₂ Nocturnal (LPM)	
O ₂ PRN (LPM)	O ₂ with Exercise (LPM)	O ₂ with CPAP/BiPAP (LPM)	
Respiratory Diagnosis/Notes			
PHYSICIAN INFORMATION			
Physician Name		Clinic Name	
Address		Practice ID#	
City/Town	Phone	Fax	
Province	Postal Code	Physician Signature	

Your trusted sleep and oxygen care provider



Sleep apnea & snoring

CPAP therapy Oral appliance therapy

Dietitian services for sleep



Insomnia & poor sleep

Cognitive behavioural therapy
for insomnia (CBT-I)



Oxygen

Home and Portable Oxygen Therapy

Respiratory Equipment and Supplies



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