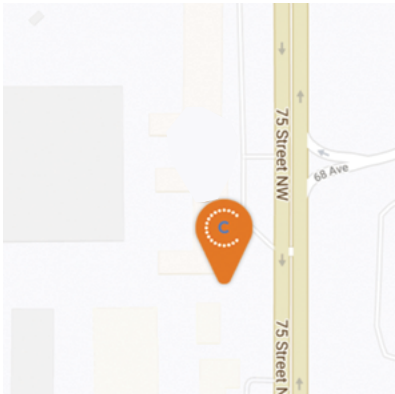


Date (DD/MM/YYYY) / /
--------------------------

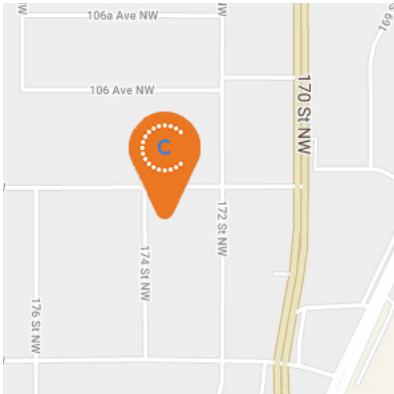
## Referral Form

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"/> <b>Sleep Apnea Diagnostics &amp; Treatment (18 yrs +)</b> Level 3 home sleep apnea test (HSAT). May include PAP treatment, OAT – as recommended.		Provided by professional partners.	
<input type="checkbox"/> <b>Level 3 Sleep Study Only</b>		<input type="checkbox"/> <b>Insomnia Cognitive Behaviour Therapy (CBT-I)</b> If probable OSA, HSAT required.	
<input type="checkbox"/> <b>PAP Trial, Treatment or Reassessment</b> Prior diagnosis required. May include HSAT.		<input type="checkbox"/> <b>Registered Dietitian Counselling</b>	
<input type="checkbox"/> <b>Oral Appliance Therapy (OAT)</b> (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)			
OXYGEN			
<input type="checkbox"/> <b>Home oxygen assessment &amp; treatment as required</b> ABG and/or PFT will be completed per provincial guidelines. If oxygen therapy indicated, oxygen will be initiated to maintain SpO <sub>2</sub> > 89%.			
SERVICE REQUISITION			
Provided by professional partners.			
<input type="checkbox"/> <b>Complete Pulmonary Function Test (PFT)</b>		<input type="checkbox"/> <b>Arterial Blood Gas (ABG)</b>	
<input type="checkbox"/> <b>Spirometry</b>		<input type="checkbox"/> <i>PaO<sub>2</sub> &lt; 60 mmHg start O<sub>2</sub> therapy</i>	
<input type="checkbox"/> <b>Respiratory consult   Level 1 study referral</b>			
PHYSICIAN INFORMATION			
Physician Name		Clinic Name	
Address		Practice ID#	
City/Town		Phone	Fax
Province	Postal Code	Physician Signature	

# Edmonton sleep clinics

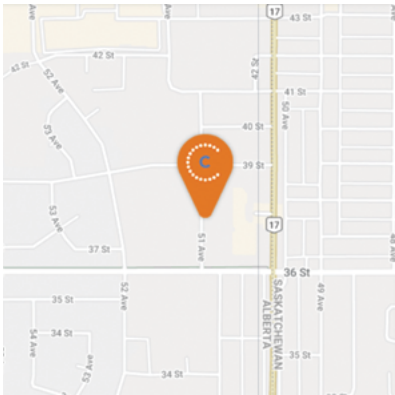


EDMONTON EAST  
6732 75 St NW  
Edmonton, AB T6E 6T9

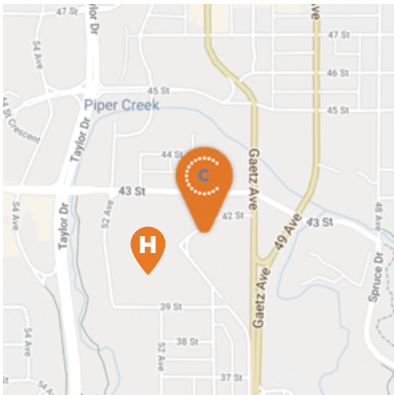


EDMONTON WEST  
10429 174 St NW  
Edmonton, AB T5S 1H1

# Lloydminster & Red Deer sleep clinics



3704 51 Ave, Unit #107  
Lloydminster, AB T9V 3M7



3947 50A Ave, Unit #204  
Red Deer, AB T4N 6V7

