CareicaHealth

FAX #:
SLEEP - ONTARIO: 437-317-9620

Date (DD/MM/YYYY)
/ /

Referral Form

PATIENT INFORMATION			
Patient Name		Email	
Address		DOB (DD/MM/YYYY) / /	
City/Town	Province	☐ Male ☐ Female Identifies as ____________	
Postal Code	Phone	PHN	

SLEEP APNEA SERVICES	ADDITIONAL SERVICES
Please note: patients must be 18+ for sleep testing. ☐ **Level 3 Sleep Apnea Diagnostics & Treatment as Required** Level 3 sleep study, consultation, APAP therapy (4/20 cm H_2O)* as recommended. **Pressures and mode adjustment as required to optimize therapy.* ☐ **APAP Trial, Treatment or Reassessment (4/20 cm H_2O)*** Prior diagnosis required or level 3 sleep study will be completed. **Pressures and mode adjustment as required to optimize therapy.*	☐ **Insomnia Cognitive Behaviour Therapy (CBT-I)** If probable OSA, sleep study required. ☐ **Registered Dietitian Counselling** Provided by professional partners.

PATIENT MEDICAL INFORMATION	
☐ Significant cardiopulmonary disease (e.g. heart failure, severe COPD)	☐ History of stroke
☐ Respiratory muscle weakness due to neuromuscular conditions	☐ Chronic opioid medication use
Reason for referral or previous sleep disorder diagnosis	
Other (e.g. medication and conditions)	

PHYSICIAN INFORMATION			
Physician Name		Clinic Name	
Address		Practice ID#	
City/Town		Phone	Fax
Province	Postal Code	Physician Signature	