SnoreMD Sleep Apnea Clinic

Changing Lives For Good

PATIENT RESPIRATORY REFERRAL

PATIENT INFORMATION

Last Name: _____ First Name: _____ M ☐ F ☐ DOB: _____

Address: _____ City: _____ Postal: _____

Phone: _____ Email: _____ PHN: _____

SLEEP APNEA TESTING AND THERAPY

COMORBIDITIES ☐ Hypertension ☐ Diabetes ☐ Obesity ☐ Cardiovascular ☐ Depression

SYMPTOMS ☐ Daytime Somnolence ☐ Unrefreshed Sleep ☐ Witnessed Apneas ☐ Habitual Loud Snoring

☐ **LEVEL 3 HOME SLEEP TEST** ☐ **STAT**

If positive for Sleep Disorders (OSA)

↓

☐ Proceed to and initiate CPAP Therapy
Prescription Range _____ to _____ cm H20

☐ Bi - Level Therapy
Prescription Range IPAP:_____ to EPAP:_____ cm H20

PATIENT MEDICAL INFORMATION / HX

_____

_____

24 HOUR BLOOD PRESSURE MONITORING

☐ **24 HOUR** Ambulatory blood pressure monitoring *(Nominal fee applies.)*

REFERRING PRACTITIONER

Referring Practitioner Name: _____ Prac ID # _____

Address: _____ City: _____ Postal: _____

Phone: _____ Fax: _____ Date: _____

Copy Results To (Physician/Healthcare Provider): _____

OPEN 6 DAYS A WEEK MON-SAT

CALGARY-CHINOOK
Phone & Fax: **(825)414-2067**

CALGARY-CREEKSIDE
Phone & Fax: **(587)329-3008**

CALGARY-WEST
Phone & Fax: **(587)329-0311**

CALGARY-SHAWNESSY
Phone & Fax: **(403)888-9355**

EDMONTON-UNITY SQUARE
Phone & Fax: **(825)414-2068**

EDMONTON-RIVERBEND
Phone & Fax: **(587)333-4003**

SHERWOOD PARK
Phone & Fax: **(587)209-0048**

LETHBRIDGE
Phone & Fax: **(587)787-3013**

Fax directly to the above clinic or 1.833.766.7363, we will contact the patient. Email us at Info@SnoreMDcanada.ca