

SLEEP APNEA REFERRAL FORM

Date _____

1 PATIENT INFORMATION

PHN _____

Name _____

DOB yyyy/mm/dd _____

Tel _____

Other _____

Address _____

Preferred Language English Punjabi Cantonese / Mandarin

Referring Physician _____ c.c. Report to _____

Tel _____

Fax _____

2 SLEEP DISORDERS ASSESSMENT

Symptoms:

- excessive daytime fatigue
- gasping / choking during sleep
- morning headaches
- frequent awakening / urination
- unrefreshed sleep
- loud snoring

Co-morbidity:

- hypertension
- diabetes
- BMI >30
- COPD
- stroke
- MI/CAD

3 SLEEP APNEA

- Overnight Oximetry
- CPAP if test results positive
- Level 3 Home sleep study
 - with interpretation
- CPAP/Auto CPAP for Sleep Apnea
 - _____ to _____ cmH2O
- BiPAP trial

4 HOME OXYGEN: _____ lpm

5 ORAL APPLIANCE

- Mandibular Advancement Device for sleep apnea/snoring fitted by Dr. Mangat (Cambie Village Sleep Dental Group).

COMMENTS (Severity/AHI/DEI)

SIGNATURE

MSP

Better sleep through technology