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Fax: 604.558.3400
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SLEEP THERAPY REFERRAL FORM

Patient Information

or Patient Label

Name: _____ Gender: Male _____ Female _____

PHN: _____ DOB: (day) _____ (month) _____ (year) _____

Address: _____ Telephone (home): _____

City: _____ Postal Code: _____ Business/Cell: _____

Primary Diagnosis: _____

Ordering Physician Contact Information

Clinic Name: _____

Referring Physician: _____ MSP #_____

Telephone: _____ Fax: _____

Reason for Referral

☐ Home Overnight Oximetry
☐ Insomnia Assessment
☐ Mandibular Oral Appliance Assessment
☐ Other: _____

☐ CPAP/BiPAP Set-up*

***If diagnosis has already been confirmed, please attach copy of sleep study results and prescription.**

Note: Requests for Level 3 Home Sleep Apnea Testing (HSAT) must now be done on the Province of B.C.'s Form A: Requisition for Home Sleep Apnea Test.

Comments: _____

_____

_____

Physician Signature: _____ **Date:** _____

Fax completed referrals to: 604 558-3400 or Scan and email to: info@vancouversleepsolutions.com