REFERRAL FOR LEVEL III HOME SLEEP STUDY

Patient Name____ Date: ____________________

PHN______________________ Date of Birth____________ Pt Email______________________________

Pt Phone___________________ Pt Cell___________________ Pt other___________________________

Address____City________________ Postal Code________

Family Physician___________________________ Phone________________ Fax___________________

Referring Physician _________________________Phone________________ Fax__________________
(if other than Family Physician)

Please Fax or Email to:

604-587-5336 (Surrey) **infosurrey@sleepbetterlivebetter.ca**

604-987-5336 (North Van) **info@sleepbetterlivebetter.ca**

Patient symptoms and/or Medical Comorbidities:

___ Hypertension ___ Cardiac Disease ___ Diabetes___ Excessive Daytime Sleepiness___ Fatigue

___ Depression___ Snoring ___ Witness Apneas ___ Previous DX Sleep Apnea

Prescription for Home Sleep Testing (Level III HSAT)

___ Please discuss results with patient and provide to my office

___ Please provide testing results to my office

Referring Physician Signature_________________________

Billing number________________

Office stamp

Dr. Sharnell Muir

Sleep Better Live Better

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