REFERRAL FOR ORAL APPLIANCE THERAPY

Patient Name_____ Date: _____

PHN_____ Date of Birth_____ Pt Email_____

Pt Phone_____ Pt Cell_____ Pt other_____

Address_____City_____ Postal Code_____

Family Physician_____ Phone_____ Fax_____

Referring Doctor _____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**

___Consultation only ___ Consultation and Therapy if appropriate

Patient symptoms and/or Medical Comorbidities:

___ Hypertension ___ Cardiac Disease ___ Diabetes___ Excessive Daytime Sleepiness___ Fatigue

___ Depression___ Snoring ___ Witness Apneas ___ Previous DX Sleep Apnea

___ Previous CPAP ___ CPAP Intolerance ___Wears CPAP would like alternative for travel etc.

Prescription for Oral Appliance Therapy

Please provide a custom oral appliance for the management of this patient's Sleep Disordered Breathing (Snoring and/or Sleep Apnea).

Referring Dr. Signature_____

Billing number_____

Office stamp

Dr. Sharnell Muir
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