REFERRAL FOR ORAL APPLIANCE THERAPY CONSULTATION

Patient Name_____ Date: _____

PHN_____ Date of Birth_____ Pt Email_____

Pt Phone_____ Pt Cell_____ Pt other_____

Address_____City_____ Postal Code_____

Family Physician_____ Phone_____ Fax_____

Original 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

Please indicate if URGENT (Severe OSA, ESS work safe)

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.

Referring Office/Clinician information: Please provide company/ therapist information

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Company office stamp

Dr. Sharnell Muir
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