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_____

Referring Dental Office/Dentist_____Phone_____

Fax_____Email_____

PLEASE Fax to:

604-587-5886 (Surrey) 604-987-5336 (North Van)

OR email to:

info@sleepbetterlivebetter.ca

infosurrey@sleepbetterlivebetter.ca

Patient symptoms:

__ High Blood Pressure __ A-Fib __ Fatigue __ Type II Diabetes__ Daytime Sleepiness

__ snores __ Witness Apneas __ Previous DX Sleep Apnea

__ Previous CPAP __ CPAP Intolerance __Wears CPAP would like alternative for travel etc.

Referring Dentist Signature_____

Office stamp

Dr. Sharnell Muir
Sleep Better Live Better
212-700 Marine Drive, North Vancouver, BC V7M 1H3
Phone: 604.987.5337 Fax: 604.987.5336 info@sleepbetterlivebetter.ca www.sleepbetterlivebetter.ca
503-13737 96 Avenue, Surrey, BC V3V 0C6
Phone: 604.587.5337 Fax: 604.587.5336 infosurrey@sleepbetterlivebetter.ca www.sleepbetterlivebetter.ca