



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)

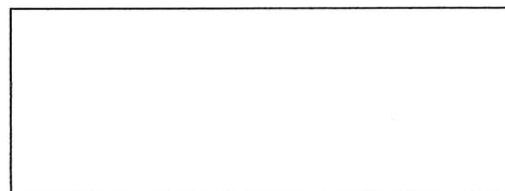
OR email to:

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
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