# REFERRAL FOR LEVEL III HOME SLEEP STUDY AND/OR CONSULTATION 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 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**

☐ **Level III Home Sleep Study** ☐ **Consultation for Oral Appliance Therapy**

**Referring Health Care Provider Information**

_____

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_____

Office stamp

_____

Signature


Dr. Sharnell Muir

*Sleep Better Live Better*

www.sleepbetterlivebetter.ca

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