



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

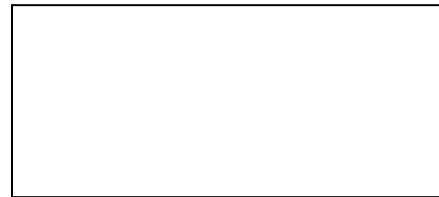
Patient symptoms and/or Medical Comorbidities:

___ 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



Office stamp

Signature

Dr. Sharnell Muir
Sleep Better Live Better
www.sleepbetterlivebetter.ca