# REFERRAL AND PRESCRIPTION FOR DIAGNOSTIC SLEEP STUDY, CONSULTATION, AND/OR ORAL APPLIANCE THERAPY PRESCRIPTION

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**

**Please include previous DX Testing and Interpretation if available**

**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.**

**Other_________________________________________________________________________**

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

***Prescription for Oral Appliance Therapy will only be filled if the patient is an appropriate candidate.**

Date: _________________________________

MD Signature:___________________________

MD Name:______________________________

Billing #:________________________________

Office Stamp


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