



## REFERRAL AND PRESCRIPTION FORM

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/ health care provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
(if other than Family Physician)

**Please Fax or Email to:**

**604-587-5336 (Surrey) [infosurrey@sleepbetterlivebetter.ca](mailto:infosurrey@sleepbetterlivebetter.ca)**

**604-987-5336 (North Van) [info@sleepbetterlivebetter.ca](mailto: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/COVID etc.

Other \_\_\_\_\_

RX Level III Home Sleep Study

Consultation

RX Oral Appliance Therapy\*

RX CBTI/BBTI Insomnia Therapy \*

RX CPAP Therapy\*

RX Right Sleep Quality Therapy\*

**Please check all that apply.** If awaiting test results prior to Rx we will return results for therapy RX signature.

**\*If TX indicated above Prescription for Therapy will only be filled if the patient is an appropriate candidate after sleep study and/or consultation and results will always be sent to you.**

MD/ND/NP Signature: \_\_\_\_\_

MD/ND/NP Name: \_\_\_\_\_

Date: \_\_\_\_\_ Billing #: \_\_\_\_\_

Office  
Stamp

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