



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

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/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*

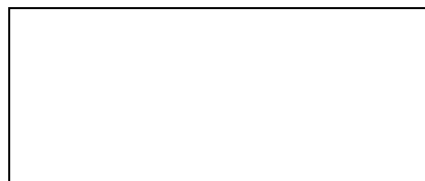
Please check all that apply. If awaiting test results prior to Rx we will return results for therapy RX signature.

***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