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

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