# REFERRAL FOR HOME SLEEP STUDY AND/OR SLEEP APNEA/SNORING/INSOMNIA CONSULTATION

Patient Name_____ Date: _____

PHN_____ Date of Birth_____ Pt Email_____

Pt Phone_____ Pt Cell_____ Pt other_____

Address_____City_____ Postal Code_____

Family Physician_____ Phone_____ Fax_____

Referring Dental Office/Dentist_____Phone_____

Fax_____Email_____

☐ **Home Sleep Study**
**(Sleep Physician Interpretation)**

☐ **Consultation for Insomnia and/or Poor Sleep**

☐ **Consultation for Snoring and Sleep Apnea therapy**

**PLEASE FAX to:**

**604-587-5886 (Surrey)  604-987-5336 (North Van)**

**OR EMAIL to:**

**info@sleepbetterlivebetter.ca**

**infosurrey@sleepbetterlivebetter.ca**

**Patient symptoms:**

**__ High Blood Pressure __ A-Fib __ Fatigue __ Type II Diabetes__ Daytime Sleepiness**

**__ Snoring __ Witness Apneas __ Previous DX Sleep Apnea __Insomnia**

**__ Previous CPAP __ CPAP Intolerance __Wears CPAP would like alternative for travel etc.**

**Referring Dentist Signature**_____

Office stamp


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