



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

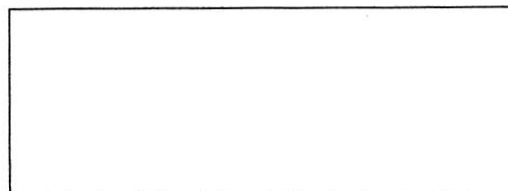
Patient symptoms:

__ 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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Sleep Better Live Better

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