# REFERRAL AND PRESCRIPTION FOR CONSULTATION AND/OR THERAPY

Patient Name_____________________________________________ Date: ____________________

PHN______________________ Date of Birth____________ Pt Email______________________________

Pt Phone___________________ Pt Cell___________________ Pt other___________________________

Address_________________________________________City________________ Postal Code________

Family Physician___________________________ Phone________________ Fax___________________

Referring 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/Victoria)** [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 etc.**

**Other**_______________________________________________________________________

- ☐ **Consultation**
- ☐ **RX Oral Appliance Therapy***
- ☐ **RX CPAP Therapy***
- ☐ **RX RightSleep Therapy***
- ☐ **RX CBTI/BBTI Insomnia Therapy***

***Prescription for Therapy will only be filled if the patient is an appropriate candidate after sleep study and consultation**

**** We are a College of Physicians and Surgeons Diagnostic Accredited Facility for HSAT, please use Form A for HSAT Referrals as can be found on our website**

Date: ________________________________

Referring Signature:___________________________

Referring Name:______________________________

Billing #:_________________________________

Office Stamp


Dr. Sharnell Muir

Sleep Better Live Better

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