



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 info@sleepbetterlivebetter.ca

*Please note that while our clinic location has moved to Pitt Meadows, we are still serving patients from all over the province

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*

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

Date: _____

Referring Signature: _____

Referring Name: _____

Billing #: _____

Office Stamp

Sleep Better Live Better

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