

SLEEP & RESPIRATORY REQUISITION

Patient Information (Please print or affix label)

Last Name: _____ Sex at Birth: M F Date of Birth: _____
(MM/DD/YYYY)

First Name: _____ Health Care #: _____

Address: _____ Phone (daytime): _____

_____ Phone (alternate): _____

City: _____ Province: _____ Postal Code: _____ Email Address: _____

Sleep

- Sleep Apnea Diagnosis & Treatment**
Interpreted HSAT Level III.
May include: CPAP, BPAP, oral appliances or as indicated
- CPAP/ BPAP Treatment**
- Reassessment of Treatment**
May include HSAT Level III and/or CPAP Treatment
- Polysomnography (Level I)**
- CBTi**
(Cognitive Behavioral Therapy for Insomnia)

Pulmonary Function

- Complete Pulmonary Function Test**
 Education Consultation
- Spirometry**
- Arterial Blood Gas (ABG)**
 PaO₂ < 60 mmHg, start O₂
- Pulmonary Rehabilitation**
- Respirologist Consultation**

Oxygen

- Oxygen Therapy**
Maintain SPO₂ > 89% (+/- ABG, PFT, HSAT Level III, Exertional Walk Test)
- Palliative Oxygen Therapy** (for comfort)
Diagnosis _____
- Assess Oxygen Requirement**

Clinic & Referring Physician (Please print or affix label)

Clinic Name: _____ Date of Referral: _____

Clinic Phone: _____ Clinic Fax: _____

Referring Doctor: _____
(Please print)

Prac ID#: _____

Physician Signature: _____

Medical Hx/Notes: _____

Please forward results to: _____

Clinic: _____

Name: _____ Fax: _____



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State-of-the-Art Facilities

A clean, comfortable, modern care environment



Expertise

A respected team of practitioners and specialists



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