IdealSleep BREATHING LTD.

Complete and fax to 236 437 2983

Patient Name:
DOB:
PHN:
Address:
City:
Phone: ❑ M ❑ F

Respiratory Services Referral Form

COVID 19:

The safety of our patients and team members remains our top priority. Our clinic will be following the necessary provincial guidelines and safety measures. We have implemented strict protocols in order to limit the spread of infection and maintain a safe environment.

Sleep Apnea Testing and Treatment: (All Data Reported to Physician)

- ❑ Level 3 Testing (Oximetry, HR, Snore, Nasal Flow, Sleep Position)
- ❑ Overnight Pulse Oximetry (In Combination with Risk Assessment Questionnaires)
  - ❑ Initiate CPAP Therapy if Positive for Sleep Disordered Breathing
  - ❑ Patient to Review Results with Physician Prior to Starting CPAP
- ❑ Re-Assessment (Machine and/or mask replacement, Patient Education)

Co-morbid Conditions

- ❑ Hypertension
- ❑ CHF
- ❑ Diabetes
- ❑ A Fib
- ❑ CAD
- ❑ BMI > 30
- ❑ Impaired Memory
- ❑ Depression
- ❑ Nocturia
- ❑ Previous Stroke

Notes: _____

_____

_____

Office Phone: _____ Office Fax: _____

Clinic Name/Address: _____

Prescribed by: _____, MD
PLEASE PRINT

Signature: _____ Date: _____

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