QUALITY
SLEEP CARE

info@qualitysleepcare.com
www.qualitysleepcare.com

☐ Mira Health Centre
Suite 108, 11910 - 111 Avenue
Edmonton, AB T5G 3G6
P 780-757-1215
FAX: 780-757-1210

☐ Edmonton South (Millwoods)
6570 - 28 Ave NW
Edmonton, AB T6L 6N3
P 780-757-1490
FAX: 780-757-1491

☐ Calgary North
Bldg.,107, 12 Ave NW
Calgary, AB T2M 0C4
P 403-220-0625
FAX: 403-220-0038

Sleep Disorder Referral Form/Prescription

Patient Name: _____ Health Care #: _____

Address: _____ Postal Code: _____

Phone: (H): _____ (C): _____

Date of Birth: _____ Male / Female

Sleep Apnea Screening and Treatment

- ☐ **Home Sleep Apnea Testing (No fee*)**
  ↳ Auto CPAP Treatment If Indicated
- ☐ **CPAP Re-Titration/Re-Assessment**
  ↳ HSAT, CPAP Treatment if Indicated
- ☐ **6 Month** (Regular Follow Up)
- ☐ **Overnight Oximetry** (Pediatrics) **(Fee*)**
- ☐ **Other Recommendations:** _____

Symptoms/Conditions

- ☐ Snoring
- ☐ Hypertension
- ☐ Gasping
- ☐ Witnessed apneas
- ☐ Diabetes
- ☐ Lung disease
- ☐ Family hx of OSA
- ☐ EDS (Excessive Daytime Sleepiness)
- ☐ Fatigue
- ☐ Mood Disorder
- ☐ Stroke
- ☐ Chronic Pain
- ☐ CHF
- ☐ MI
- ☐ Asthma/COPD

Reason for Referral/Medical History: _____

_____

_____

Referring Physician and Clinic: _____

_____

Dr. Signature: _____ Date: _____

Phone: _____ Fax: _____

**All results interpreted by a Qualified Sleep Physician*

Additional Assistance

- ☐ Send digital copy of referral form
- ☐ Send another pad of referral forms
- ☐ Contact our clinic to schedule an educational session with our staff
- ☐ Assist in referral to specialist

stamp