OKANAMED SLEEP APNEA

CPAP Therapy & Supplies
Home Sleep Tests
Home Visits throughout the Okanagan Valley

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Physician Referral Form

Date of Referral (dd-mm-yy): _____

Patient Name: DOB (dd-mm-yy): PHN: Gender: ☐ Female ☐ Male ☐ Other	Address: Home Phone: Cell Phone:

Reason for Referral/Presenting Problem:_____

Procedure:

Nocturnal Oximetry - Simple
Level III Oximetry - Detailed Home Sleep Test
Proceed to CPAP if indicated by interpretation or results
CPAP/BiPAP/ASV Start with Prescription as follows;
_____
_____
CPAP/BiPAP assessment and/or follow-up

Additional Comments:_____
_____
_____
_____

Referring Physician: _____ Ph:_____
Fax:_____

Physician Signature: _____

Thank you for your referral