



SLEEP & RESPIRATORY REQUISITION

Sleep Diagnostics & Therapy | Oxygen Therapy | Pulmonary Diagnostics

Patient Information

Last Name: _____
 First Name: _____
 Sex M F | Date of Birth (mm/dd/yy): _____
 Address: _____

 Phone (Daytime): _____
 Email: _____
 Health Card #: _____

Patient Label

SLEEP - NO COST AT HOME SLEEP TESTING

- Sleep Apnea & Snoring Diagnostics
 Interpreted Home Sleep Apnea Testing (HSAT Level III)
 May include CPAP Treatment, Oral Appliance,
 Provent Therapy - As Indicated
- CPAP Treatment
 Requires previous diagnosis
- Re-assessment of Treatment
 May include HSAT. CPAP treatment - As Indicated
- Oral Appliance Therapy Consultation
 HSAT and/or MATRx Titration PSG - As Indicated
- Other _____

 Insomnia, Restless Leg Syndrome, Shift Work, etc.

OXYGEN

- Oxygen Therapy
 Maintain SpO₂ > 89% | +/- ABG, PFT, HSAT, Exercise
 Oximetry as required by AADL Funding
- Assess Oxygen Requirement

DIAGNOSTICS

- Complete Pulmonary Function Test
- Spirometry
- Arterial Blood Gas (ABG)
 <60 PaO₂ start O₂

Medical Hx / Notes: _____

- Snoring Hypertension Diabetes Cardiovascular Disease

Referring Physician/Practitioner Information

- Please confirm receipt of fax

Clinic Stamp Including Fax #

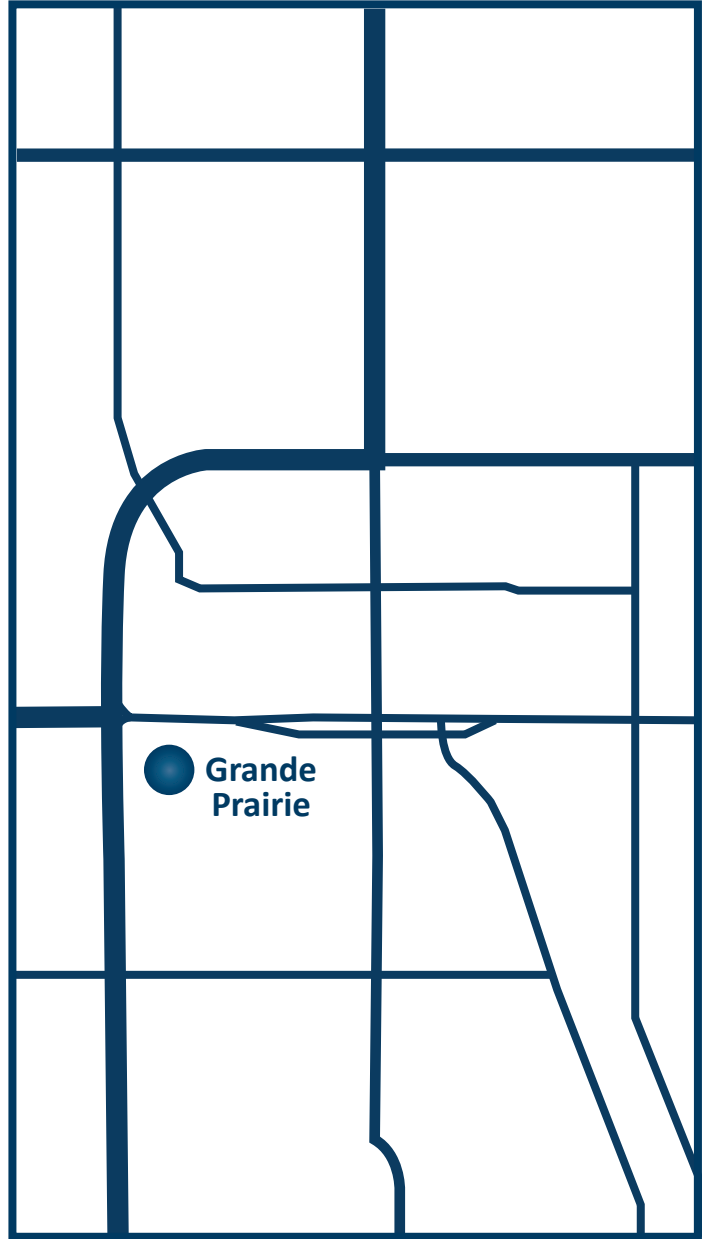
Name: _____
 Signature: _____
 Prac ID: _____
 Date: _____
 Fax Mandatory: _____
 Phone: _____
 Clinic: _____

- Please forward screening results to treating physician. (If checked please include the following information):

Name: _____ Fax: _____ Clinic: _____



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