

SLEEP & RESPIRATORY REQUISITION Sleep Diagnostics & Therapy | Oxygen Therapy | Pulmonary Diagnostics

Phone: (403) 217-5337 | Fax: (403) 243-7058

Patient Information			
Last Name:		- Patient Label	
First Name:			
•	e of Birth (mm/dd/yy):		
Address:			
 City:	Postal Code:		
Health Card #:			
SLEEP - NO COST AT HOI	ME SLEEP TESTING	OXYGEN	
☐ Sleep Apnea & Snoring Diagnostics Interpreted Home Sleep Apnea Testing (HSAT Level III) May include CPAP Treatment, Oral Appliance, As Indicated		☐ Oxygen Therapy Maintain SpO₂ > 89% +/- ABG, PFT, HSAT, Exercise Oximetry as required by AADL Funding	
		☐ Assess Oxygen Requirement	
		☐ CPAP Treatment	
Requires previous diagnosis			
☐ Re-assessment of Treatment May include HSAT. CPAP treatment - As Indicated			
	0 11 11	DIAGNOSTICS	
☐ Oral Appliance Therapy Consultation		☐ Complete Pulmonary Function Test	
- 0 11		☐ Spirometry	
□ Other		☐ Arterial Blood Gas (ABG)	
Insomnia, Restless Leg Syndrome, Shift Work, etc.		□ <60 PaO₂ start O₂	
		□ <00 PdO2 Stdft O2	
Medical Hx / Notes:			
☐ Snoring	☐ Hypertension	☐ Diabetes	☐ Cardiovascular Disease
Referring Physician/	Practitioner Information		
☐ Please confirm receipt of fax		Name:	
Clinic Stamp Including Fax #		Signature:	
		Prac ID:	
		Phone:	
		Clinic:	
☐ Please forward scr	reening results to treating physician.	(If checked please include:	the following information):
	come results to treating prijoteitin.	streemed predoc morade	
Name:	Fax:	C	linic:





*LOCATIONS ARE NOT ON MAP

