



SLEEP & RESPIRATORY REQUISITION

Sleep Diagnostics & Therapy | Oxygen Therapy | Pulmonary Diagnostics

Phone: (403) 347-6707

Fax: (403) 347-6750

rhscanada.com

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,
As Indicated

☐ CPAP Treatment
Requires previous diagnosis

☐ Re-assessment of Treatment
May include HSAT. CPAP treatment - As Indicated

☐ Oral Appliance Therapy Consultation

☐ 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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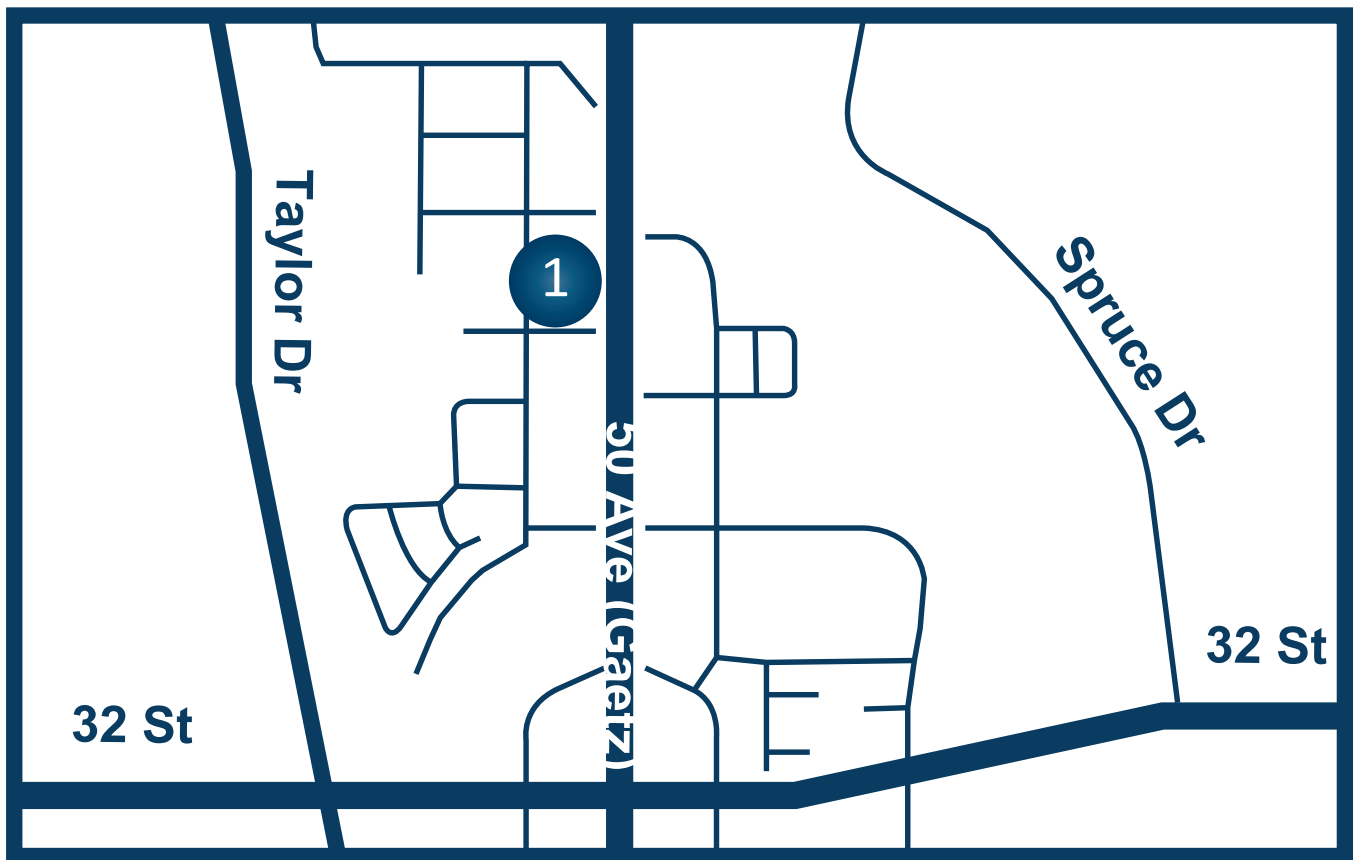
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***BY APPOINTMENT ONLY**