Ontario Sleep Care CPAP

Email: info@ontariosleepcare.ca
Fax: 905-878-0660
Toll Free: 1-844-823-0685

Sleep Services Referral Form

Patient Information

Last Name	First Name		Sex M ☐ F ☐
Address	City	Prov	Postal Code
Daytime Telephone	Other Telephone	Date of Birth (DDMMYYYY)	
Diagnosis		AHI	

☐ **PAP Trial (Auto-Titration device)**

***Min Pressure*_____ cmH2O**
***Max Pressure*_____ cmH2O**

☐ **PAP Device Purchase**

☐ **CPAP Therapy** - ***Fixed Pressure*** _____**cmH2O**

☐ **APAP Therapy** - ***Min Pressure*_____ cmH2O** ***Max Pressure*_____ cmH2O**

☐ **BI-Level Auto Therapy** - ***IPAP*_____ cmH2O** ***EPAP*_____ cmH2O** ***Other*_____**

☐ **PAP Mask & Accessories** - **Nasal Mask** ☐ **Nasal Pillows** ☐ **FFM** ☐ **Patient Choice** ☐

☐ **Oximetry Overnight Screening**

Notes:

Referrer Information

Physician Name	Tel	Fax
Date (DDMMYYYY)	Physician Signature	

CONSIDERED A VALID PRESCRIPTION WHEN SIGNED BY A PHYSICIAN