

# Sleep Services Referral Form

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## Patient Information

Last Name		First Name		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Address		City	Prov	Postal Code	
Daytime Telephone	Other Telephone		Date of Birth (DDMMYYYY)		
Diagnosis			AHI		

- PAP Trial (Auto-Titration device)**       **PAP Device Purchase**  
     *Min Pressure* \_\_\_\_\_ cmH2O  
     *Max Pressure* \_\_\_\_\_ cmH2O
- 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**