SLEEPLIFE

sleeplifeatlantic.com

PATIENT REFERRAL

Fax to: 844-994-1331
Email to: info@sleeplifeatlantic.com

PATIENT INFORMATION

FIRST NAME | LAST NAME | DATE OF BIRTH (DD/MM/YYYY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

PHONE # (CELL) | PHONE # (HOME) | EMAIL ADDRESS

PATIENT DIAGNOSIS & CO-MORBIDITIES *(If known, check off all that apply)*

- ☐ UARS
- ☐ MILD OSA
- ☐ MODERATE OSA
- ☐ SEVERE OSA

- ☐ HYPERTENSION
- ☐ DIABETES
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ GERD
- ☐ RLS
- ☐ COPD

- ☐ ATRIAL FIBRILLATION
- ☐ PREVIOUS STROKE
- ☐ PTSD
- ☐ OTHER CARDIAC DISEASE
- ☐ _____
- ☐ _____

Additional Information:

BRIEF CLINICAL HISTORY

REFERRAL REQUEST

- ☐ SLEEP STUDY TESTING
- ☐ CPAP MACHINE & MASK *(WITH 1 MONTH TRIAL)*
- ☐ REPLACEMENT CPAP MACHINE & MASK
- ☐ FOLLOW UP CARE *(CURRENTLY ON DEVICE)*
- ☐ OTHER:

PREFERRED LOCATION

- ☐ Bedford, NS
- ☐ Windsor, NS
- ☐ Sydney NS
- ☐ Fredericton, NB
- ☐ St. John's, NL
- ☐ Port Aux Basques, NL

PHYSICIAN / NP INFORMATION

PHYSICIAN/NP NAME | SIGNATURE

LICENCE # | DATE