



DREAM SLEEP RESPIRATORY

# PATIENT REFERRAL FORM

## SLEEP APNEA TESTING - CPAP THERAPY - HOME OXYGEN

PLEASE FAX TO: (403) 986-9901 OR EMAIL TO: [INFO@DREAMSLEEP.CA](mailto:INFO@DREAMSLEEP.CA)

INQUIRIES PLEASE CALL: (403) 754-4315

<b>Patient Information (or Patient Label)</b>		Date (YY/MM/DD): _____
Patient First Name: _____	Patient Last Name: _____	
Street Address: _____	City / Town: _____	
Postal Code: _____	Sex (M/F): _____	
Home Phone: _____	Business Phone: _____	
AHC Number: _____	Date of Birth (YY/MM/DD) _____	

**Sleep Services**

Level-3 Sleep Study<sup>1</sup>

CPAP Trial

CPAP Reassessment / Intervention

Dental Appliance Therapy Consultation<sup>2</sup>

Other (Insomnia, restless leg syndrome, shift work)

**Pulmonary Function Services (Check all that Apply)**

Routine  Urgent

Complete Testing<sup>3</sup>  Spirometry<sup>4</sup>

Reason for Testing: \_\_\_\_\_

Repeat Testing Every \_\_\_\_\_ (Months) \_\_\_\_\_ (Years)

**Home Oxygen Services (Please Check All That Apply)**

Diagnosis: \_\_\_\_\_

Oxygen Assessment (Spirometry as Required)

Oxygen therapy \_\_\_\_\_ LPM \_\_\_\_\_ Hours/day

Maintain SpO<sub>2</sub> > 89%

Arterial Blood Gas (as per AADL Guidelines)

Other \_\_\_\_\_

**Clinic Information (Or Stamp)**

Clinic name: \_\_\_\_\_

Office phone: \_\_\_\_\_

Office fax: \_\_\_\_\_

Prac ID: \_\_\_\_\_

Referring DR: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Notices and Special Instructions:**

1. May include - CPAP trial / treatment, oral appliance, referral to sleep specialist / PSG, Spirometry, and/or PFT.

2. May require a level-3 sleep study

Please be advised that all patients referred for pulmonary function testing will be asked, unless otherwise directed by the referring physician, not to use any bronchodilators (Ventolin, Airomir, Bricanyl, Formoterol, Salmeterol, and Atrovent) for at least 4 – 6 hours prior to the test. Also not to use Spiriva, Advair, and Symbicort for at least 24 hours prior to testing. Patients should not smoke or use any caffeine for at least 4 hours prior to testing. PFT testing in Red Deer performed by Central Alberta Lung Lab.

### STOP BANG Questionnaire located on back of form:

Please mark the number of questions answered in the positive "YES" and record the score in the space provided.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

SCORE: \_\_\_\_\_

**CHECK PREFERRED CLINIC LOCATION & FAX TO 403-986-9901**

<input type="checkbox"/> <b>Calgary North W</b> Country Hills Village Unit 222 - 5149 Country Hills BLVD NW Calgary, AB T2Z 4Y5	<input type="checkbox"/> <b>Calgary North E</b> Sunridge Junction 5118 - 2255 32 Ave NE Calgary, AB T1Y 6E3	<input type="checkbox"/> <b>Calgary South</b> South Trail Crossing Suite 63 - 4307 130th Ave SE Calgary, AB T2Z 3V8	<input type="checkbox"/> <b>Canmore</b> <i>Appointment Only</i> #4A - 1306 Bow Valley Trail Canmore, AB T1W 1N6	<input type="checkbox"/> <b>Red Deer</b> Canyon Plaza Suite 3, 3701 50th Ave Red Deer, AB T4N 3Y7
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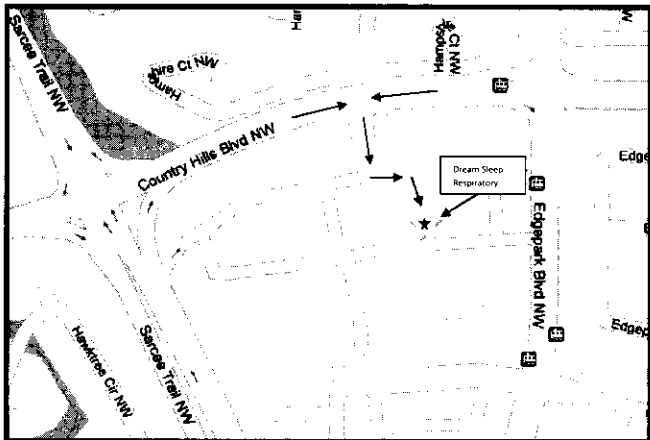
Dream Sleep Respiratory - Breathing Made Easy!

SLEEP STUDIES - CPAP THERAPY - PULMONARY FUNCTION TESTING - HOME OXYGEN

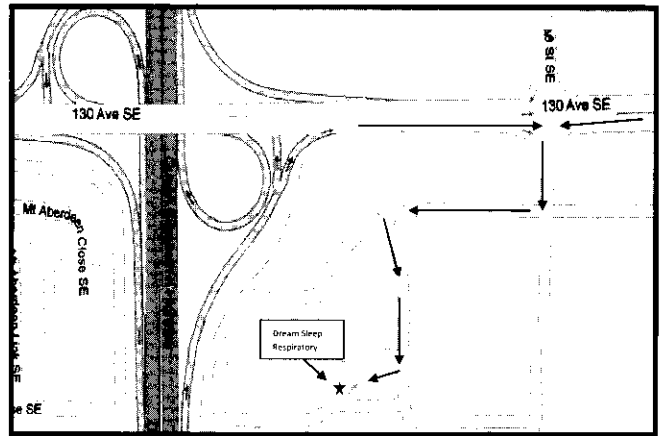
[www.dreamsleep.ca](http://www.dreamsleep.ca) / [www.calgaryhomeoxygen.ca](http://www.calgaryhomeoxygen.ca)



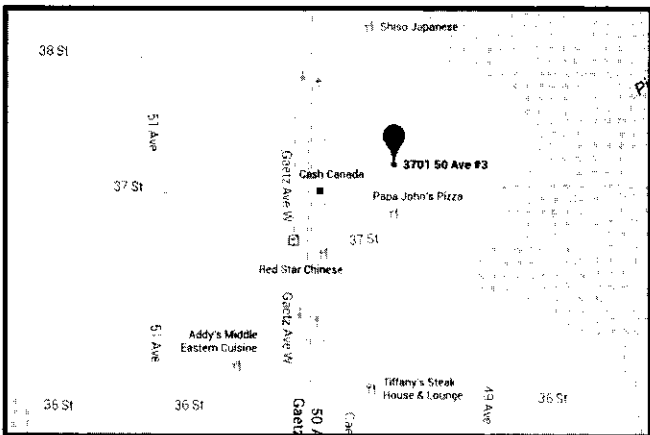
**North West Calgary:**  
Unit 202 - 5149 Country Hills Blvd NW T3A 5K2  
(Country Hills Village)



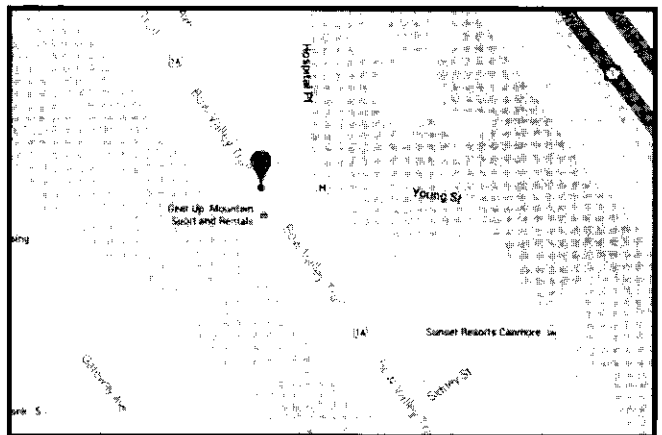
**South East Calgary:**  
Suite 63 - 4307, 130th Avenue SE T2Z 3V8  
(South Trail Crossing)



**Red Deer:**  
#3, 3701 - 50th Ave  
Red Deer, AB. T4N-3Y7



**Canmore:**  
#4A - 1306 Bow Valley Trail  
Canmore, AB. T1W1N6



## STOP BANG QUESTIONNAIRE

Yes  No **S**nooring? Do you Snore Loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night?

Yes  No **T**ired? Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving)?

Yes  No **O**bserved? Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?

Yes  No **P**ressure? Do you have or are being treated for High Blood Pressure?

Yes  No **B**ody Mass Index more than 35 kg/m<sup>2</sup>? Or, What is your height \_\_\_\_\_ (ft) or (M) & How much do you weigh \_\_\_\_\_ (lbs) or (kg)?

Yes  No **A**ge older than 50?

Yes  No **N**eck size large? (Measured around Adams apple)

For male, is your shirt collar 17 inches / 43 cm or greater?

For female, is your shirt collar 16 inches / 41 cm or greater?

Yes  No **G**ender = Male?

*A score of 3 or higher indicates need for a sleep study*