Date of referral:_____

DSR
DREAM SLEEP RESPIRATORY
*"Breathing Made Easy"*

This facility is accredited by cpsa

ACCREDITED ACCREDITATION CANADA AGRÉMENT CANADA AGRÉÉ

## SLEEP APNEA TESTING - CPAP THERAPY - HOME OXYGEN - BIPAP THERAPY

**P: (403) 303+6/ . / • F: (2 . 1) 265+1/ 4/ • DREAMSLEEP.CA**

**Patient Information / Patient Label**

Last Name: _____

First Name: _____

Address: _____

Gender: ❑ M ❑ F Date of birth: _____

Daytime Phone: _____

AHC Number: _____

**Referring Physician / Clinic Information / Label**

Clinic Name: _____

Office Phone: _____

Office Fax: _____

Referring Physician: _____

Prac ID: _____

Signature: _____

### Sleep Services

❑ Level-3 Sleep Diagnostics

❑ Jctcj+1 Qjccn Bg_e l mqrgaq _ l b AN?N R f cp_nw

❑ Jctcj+1 Qjccn R f cp_ncsrga Qrsbw

❑ Conservative measures for snoring (AHI<5)[2]

❑ TN?N &T?srm' Rpg_j-R f cp_nw &AN?N Non-Am k njg_ l r Sqcpq'

❑ AN?N Pc_qqcqq k c l r - ¢ l rcp t c l rgm l [1]

❑ CPAP Therapy

❑ Settings:_____

Reason for Testing:_____

### Home Oxygen Services (Please Check All That Apply

Diagnosis:

❑ Oxygen Assessment (Spirometry as Required)

❑ Oxygen therapy _____ LPM _____ Hours/day

❑ Maintain SpO > 89%

❑ Arterial Blood Gas (as per AADL Guidelines)

❑ Other: _____

### Notices and Special Instructions:

1. May require a Level-3 Sleep Study.
2. Positional sleep aid with anti snoring mouth piece (Pure Sleep Device).

**Physician Comments:** _____

_____

_____

**Please forward screening results to treating physician (If applicable please include the following information):**

Physician: _____ Fax: _____ Clinic: _____

**Available on Most EMR Systems**

**COUNTRY HILLS VILLAGE**
202-5149 COUNTRY HILLS BLVD NW
CALGARY, AB
T3A 5K8

**SOUTH TRAIL CROSSING**
63-4307 130 AVE SE
CALGARY, AB
T2Z 3V8

**STRATHCONA SQUARE**
212-555 STRATHCONA BLVD SW
CALGARY, AB
T3H 2Z9

**BURNSWEST BUSINESS CENTRE**
BAY 8, 21 HIGHFIELD CIRCLE SE
CALGARY, AB
T2G 5N6

**SUMMIT PLACE**
4A-1306 BOW VALLEY TRAIL
CANMORE, AB
T1W 1N6
APPOINTMENTS ONLY

**CANYON PLAZA**
3-3701 50 AVE
RED DEER, AB
T4N 3Y7

**OLDS PLAZA**
3-4530 49 AVE
OLDS, AB
T4H 1A4

**CURRENTS OF WINDERMERE**
6113 CURRENTS DR NW
EDMONTON, AB
T6W 2Z4

**MANNING TOWN CENTRE**
15369 37 ST NW
EDMONTON, AB
T5Y 0S5

**FIRESIDE GATE**
5102-50 FIRESIDE GATE
COCHRANE, AB
T4C 2P3

**LETHBRIDGE**
1010 MAYOR MAGRATH DR. S
LETHBRIDGE, AB
T1K 2P8

**MEDICINE HAT**
101-1424 SOUTHVIEW DRIVE SE
MEDICINE HAT, AB
T1B 4E7

# STOP BANG QUESTIONNAIRE

☐ Yes ☐ No **S** **noring?** 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 day (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$^2$?** 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*