



DREAM SLEEP RESPIRATORY
"Breathing Made Easy"

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

P: (403) 539-8418 • F: (587) 425-2730 • 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 Study¹

CPAP Trial

CPAP Reassessment / Intervention²

Dental Appliance Therapy Consultation²

Level-3 Sleep Therapeutic Study

CPAP Therapy

Settings _____

Home Oxygen Services (Please Check All That Apply)

Diagnosis:

Oxygen Assessment (Spirometry as Required)

Oxygen therapy _____ LPM _____ Hours/day

Maintain SpO₂ > 89%

Arterial Blood Gas (as per AADL Guidelines)

Other _____

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.

Physician Comments: _____

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

Physician: _____ Fax: _____ Clinic: _____



COUNTRY HILLS VILLAGE

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

OLDS PLAZA

3-4530 49TH AVE
OLDS, AB
T4H 1A4

SOUTH TRAIL CROSSING

63-4307 130TH AVE SE
CALGARY, AB
T2Z 3V8

CURRENTS OF WINDERMERE

6113 CURRENTS DR NW
EDMONTON, AB
T6W 2Z4

STRATHCONA SQUARE

212-555 STRATHCONA BLVD SW
CALGARY, AB
T3H 2S8

MANNING TOWN CENTRE

15369 37TH ST NW
EDMONTON, AB
T6L0S5

BURNSWEST BUSINESS CENTRE

BAY 8, 21 HIGHFIELD CIRCLE SE
CALGARY, AB
T2G 5N6

FIRESIDE GATE

5102-50 FIRESIDE GATE
COCHRANE, AB
T4C 2P3

SUMMIT PLACE

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

LETHBRIDGE

1010 MAYOR MAGROTH DR. S
LETHBRIDGE, AB
T1K 2P8

CANYON PLAZA

3-3701 50TH AVE
RED DEER, AB
T4N 3Y7

STOP BANG QUESTIONNAIRE

Yes No **S**norring? 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/m²? 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