



CLINICAL SLEEP SOLUTIONS INC.

Patient's Name: _____

PHN: _____ D.O.B. ____/____/____ Phone: _____

Address: _____

Obstructive Sleep Apnea

Screening

- Overnight Oximetry
- ApneaLink
- Remmers Sleep Recorder
- Interpretation

CPAP Trial

- CPAP _____ cmH2O
- Auto-CPAP
min ____ cmH2O max ____ cmH2O
- Bi-PAP
IPAP ____ cmH2O EPAP ____ cmH2O
- ASV
- Titrate as necessary

Sleep Assessment

- Assessment**
Consultation
Sleep Hygiene
Overnight Oximetry (if necessary)
Summary Report

Circadian Rhythm Disorders

- Light Therapy**
 - Seasonal Affective Disorder
 - Delayed Circadian Rhythm
 - Advanced Circadian Rhythm
 - Jet Lag
 - Shift Work

- Oral Appliance for Snoring**

Special Instructions: _____

Physician Name: _____ Date: _____

Signature: _____

Please fax or mail your prescription to one of our offices:

- | | | |
|---|--|------------------|
| <input type="checkbox"/> #103 - 805 W. Broadway, Vancouver | Tel 604-875-1440 | Fax 604-875-1469 |
| <input type="checkbox"/> #115 - 5050 Kingsway, Burnaby | Tel 604-432-9271 | Fax 604-432-9471 |
| <input type="checkbox"/> #180 - 7031 Westminster Hwy, Richmond | Tel 604-278-1540 | Fax 604-278-1567 |
| <input type="checkbox"/> #209 - 1940 Lonsdale, North Vancouver | Tel 604-985-1440 | Fax 604-985-9471 |
| Web: www.clinicalsleepon.com | E-Mail: info@clinicalsleepon.com | |