Clinical Sleep SOLUTIONS

Patient's Name: Gender: ☐ Male ☐ Female

MSP: D.O.B. mm / dd / yyyy Phone:

Address:

Obstructive Sleep Apnea

Sleep Study

- ☐ Level III Sleep Study w/ interpretation
  - ☐ Start CPAP trial if OSA indicated on interpretation
- ☐ Overnight Oximetry
- ☐ Overnight Oximetry with CPAP

Treatment

- ☐ CPAP Therapy _____ cmH_2O
- ☐ BiPAP Therapy _____ cmH_2O
- ☐ Titrate as necessary

Sleep Assessment

☐ Assessment

- Consultation
- Sleep Hygiene Education
- Level III Portable Monitor (if necessary)

Home Oxygen

☐ Home O_2 _____ L/min

- ☐ 24 Hours
- ☐ Nocturnal O_2
- ☐ with Exertion

Special Instructions:

Referring Physician:

Signature:

Date:

Clinic Name or Stamp:

Please print and fax or email your prescription to one of our offices:

☐ #115 - 5050 Kingsway, Burnaby	Tel: 604.432.9271	Fax: 604.432.9471
☐ #103 - 805 West Broadway, Vancouver	Tel: 604.875.1440	Fax: 604.875.1469
☐ #180 - 7031 Westminster Hwy, Richmond	Tel: 604.278.1540	Fax: 604.278.1567
☐ #107 - 1461 Johnston Rd, White Rock	Tel: 604.542.2276	Fax: 604.542.2216
☐ #215 - 1433 Lonsdale Ave, North Vancouver	Tel: 604.985.1440	Fax: 604.985.9471
☐ #101-1695 Marine Drive, West Vancouver	Tel: 778.650.0380	Fax: 604.985.9471
☐ #2 - 38003 2nd Ave, Squamish	Tel: 604.390.1130	Fax: 604.390.1131
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