SleepEasy

CPAP

Your Sleep Apnea Solutions

Sleep Easy CPAP Ltd. Level III Sleep Study Referral Form

Name of Patient _____ Date _____

Address _____ Completed By _____

Date of Birth _____

Phone _____

Diagnosis _____

Comments _____

Doctor's Request:

- ☐ **Level III Sleep Study**
- ☐ **Interpret Sleep Study**
- ☐ **CPAP Trial**
  (if study is positive)

If any of these symptoms apply to your patient: We can help

- **S** Snoring
- **L** Lack of Energy
- **E** Excessive Daytime Sleepiness
- **E** Episodes of gagging or choking
- **P** Persistant Morning Headaches

If the study is interpreted by the Sleep Specialist as positive, with the recommendation for CPAP therapy, we will proceed to trial of CPAP. When trial is completed, we will forward the results back to you for review.

Referring Physician _____

Physician's signature _____

Physician's phone _____ Physician's Fax _____

PLEASE FAX THIS REFERRAL TO: 780-757-1594

We will contact the patient directly and make all of the arrangements

4023 97 Street NW, Edmonton, AB T6E 5Y5
Office Phone: 780-801-0855