SLEEP EASY CPAP LTD
4023 97 Street NW, EDM
Phone: 780-801-0855
REFERRAL FORM

ACCREDITED BY College of Physicians & Surgeons of Alberta

PATIENT INFORMATION:			
Last Name:	First Name:	☐ Male	☐ Female
Address:			
City:	Province:	Postal Code:	
Phone:	PHN#:	DOB: MM/DD/YY	
Contact Name:	Contact Phone:		
Additional Patient Information:			

REFERRAL SOURCE:	
Facility or Address:	**PHYSICIAN PHONE:**
	PHYSICIAN FAX:

PHYSICIAN'S REQUEST:	SLEEP CONCERNS:		MEDICAL CONDITIONS:	
☐ **LEVEL III SLEEP STUDY** HSAT testing	Excessive Daytime Sleepiness	☐	Hypertension	☐
	Morning Headaches	☐	Neuromuscular Disease	☐
	Frequent Awakenings	☐	Diabetes	☐
☐ **CPAP TRIAL** if study is positive	Witnessed Apneas	☐	Depression	☐
	Snoring	☐	Anxiety	☐
	Drowsy Driving	☐	CHF	☐
☐ **EXISTING CPAP PATIENT** requires follow up	Sleep Walking	☐	Asthma/COPD	☐
	Insomnia	☐	Cardiac Arrhythmias	☐
	Shift Work	☐	Chronic Pain	☐
	Professional Driver	☐	Other:	☐

Physician Name:	Date:
Practitioner ID:	
Physician Signature:	

PLEASE FAX THIS REFERRAL TO: 780-757-1594

Sleep Easy Office Use Only:
Referral Received
Patient Contacted#1
Patient Contacted#2
Patient Contacted#3

APPOINTMENT BOOKED: