PH: 604.227.5355 FAX: 604.227.5867
Unit 5, 1363 - 56th Street, Delta, BC V4L 2P7
admin@baysidesleepsolutions.com

REFERRING PHYSICIAN
NAME
ADDRESS
PHONE
FAX
EMAIL

SLEEP DIAGNOSTICS REFERRAL FORM

PATIENT INFORMATION		
LAST NAME	FIRST NAME	
HOME ADDRESS		
DATE OF BIRTH Day Month Year	HOME PHONE	WEIGHT (kg)
BC CARE CARD	CELL PHONE	HEIGHT (cm)
SEX ❑ MALE ❑ FEMALE	EMAIL	

SLEEP DIAGNOSTICS	TRIAL	TREATMENT
☐ LEVEL 3 DIAGNOSTIC AMBULATORY SLEEP STUDY ☐ OVERNIGHT OXIMETRY ☐ LEVEL 3 DIAGNOSTIC AMBULATORY SLEEP STUDY with AutoPAP Pressures: ________ - ________ cmH_2O	☐ AutoPAP TITRATION/TRIAL *(If Required)* **Settings:** 5 - 20 cmH_2O **OR** 8 - 20 cmH_2O *(Depending on severity of OSA)*	☐ AutoPAP THERAPY Pressures: ________ - ________ cmH_2O *(With Heated Humidifier and Mask)* **OR** ☐ STANDARD CPAP THERAPY Pressure: __________ cmH_2O *(With Heated Humidifier and Mask)*

SPECIAL INSTRUCTIONS

PHYSICIAN SIGNATURE	DATE
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