Home Sleep Apnea Test Referral

Fax referrals to 519 286 4191

Referring Physician

Name of Referring Physician: _____

Billing #: _____

Phone Number: _____

Fax Number: _____

Is this physician the patient's primary care provider? Yes☐ No ☐

Patient Name : _____

Cell # : _____

Email : _____

DOB : _____

☑ REASON FOR REFERRAL

☐ Assessment of Sleep Apnea (OSA)

☑ REQUESTED SERVICE
(Select One)

☐ HSAT Only

☐ HSAT plus Physician Companion Program Referral
HSAT plus sleep consultation and management

Contraindications for home sleep apnea testing

- *Cellular access*
- *A permanent pacemaker*
- *Under the age of 12, less than 65lbs*
- *Paediatric patient (12-17) with severe comorbidities such as Down syndrome, neuromuscular disease, underlying lung disease or obesity hypoventilation*
- *Sustained arrhythmias*
- *Injury or deformities to sensor sites (finger, wrist or chest)*
- *Use of one of alpha blockers, short acting nitrates (less than 3 hours before the study)*

WLW USE ONLY (Physician Companion):

Referral Accepted by client and WLW: _____

Date of Consultation appointment : _____ Time:_____

Assigned Companion Physician: _____

Contact us:
Phone: 519 286 4191
Email: info@worklifewellness.ca
www.worklifewellness.ca