1-587-333-0559 A2ZSleep.ca 1-833-664-6698

REQUISITION FORM

Date: _____

PATIENT INFO

(Please use address label with valid phone number)

Patient Name: _____

Address: _____

City: _____

Prov: _____ Postal Code: _____

Date of Birth: _____ Male: ☐ Female: ☐

Provincial Health #: _____

Contact Phone #: _____

OFFICE

Referring MD/NP: _____

Referring MD/NP Prac ID: _____

Referring MD/NP Signature: _____

Referring ph: _____

Referring fax: _____

Family MD/NP: _____

ADULT SLEEP MEDICINE

☐ FULL SLEEP ASSESSMENT (Sleep assessment with provider including appropriate diagnostics and follow up)

☐ HOME SLEEP APNEA TEST ONLY (HSAT +/- therapuetic trial)

☐ CPAP EDUCATION/SERVICE APPOINTMENT (Patient may or may not incur a cost).

☐ OTHER: _____

OXYGEN

☐ SUPPLEMENTAL OXYGEN THERAPY (Maintain SPO2 > 89%, +/- ABG, PFT, HSAT Level III, Exertional Walk Test)

PULMONARY FUNCTION

☐ FULL PULMONARY FUNCTION TESTING (includes Pre- and Post-Bronchodilator Spirometry, Diffusion, Lung Volumes)

☐ SPIROMETRY PROTOCOL (includes Pre- and Post-Bronchodilator Spirometry; may include Diffusion Capacity and Lung Volumes)

☐ ARTERIAL BLOOD GAS

☐ OTHER: _____

Additinal Information:

OUR LOCATIONS:

CALGARY SW
850, 10655 Southport Rd SW
Calgary, AB
T2W 4Y1

RED DEER
265, 5201 43rd St
Red Deer, AB
T4N 4B4