

# SLEEP & RESPIRATORY REQUISITION

## Patient Information (Please print or affix label)

Last Name: \_\_\_\_\_ Sex at Birth:  M  F Date of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

First Name: \_\_\_\_\_ Health Care #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone (daytime): \_\_\_\_\_  
 \_\_\_\_\_ Phone (alternate): \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Sleep

- Home Sleep Apnea Test (Level 3) & CPAP treatment
- Auto CPAP treatment
- Reassessment of Treatment HSAT and/or CPAP
- Polysomnography (Level 1)
- Home Polysomnography (Level 2)
- Home Sleep Apnea Test Only (Level 3)

### Pulmonary Function

- Complete Pulmonary Function Test
- Spirometry
- Arterial Blood Gas (ABG)
  - PaO<sub>2</sub> < 60 mmHg, start O<sub>2</sub>
- Pulmonary Rehabilitation
- Respirology Consult  
Attach Referral Letter

### Oxygen

- Oxygen Therapy  
Maintain SPO<sub>2</sub> > 89% (+/- ABG, PFT, HSAT Level III, Exertional Walk Test)
- Palliative Oxygen Therapy (for comfort)  
Diagnosis \_\_\_\_\_
- Assess Oxygen Requirement

Special Requests: \_\_\_\_\_

Medical Hx/Notes: \_\_\_\_\_

## Clinic & Referring Physician (Please print or affix label)

Clinic Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Clinic Phone: \_\_\_\_\_ Clinic Fax: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_  
(Please print)

Prac ID#: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Please forward results to: Clinic: \_\_\_\_\_  
 Name: \_\_\_\_\_ Fax: \_\_\_\_\_



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 Or visit [maplerespiratory.com](http://maplerespiratory.com)

# The Maple Respiratory Group Experience

Patients are put at ease from the second they walk into one of our modern clinics. Physicians can be confident knowing their patients are receiving the highest standard of care in our state-of-the-art facilities.



## Prompt Testing

Book appointments to fit your schedule at any of our locations.



## State-of-the-Art Facilities

A clean, comfortable, modern care environment



## Expertise

A respected team of practitioners and specialists



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