

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)
 - PaO₂ < 60 mmHg, start O₂
- Pulmonary Rehabilitation
- Respirology Consult
Attach Referral Letter

Oxygen

- Oxygen Therapy
Maintain SPO₂ > 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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