AMHERST OFFICE
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Amherst, NS B4H 4R7
T: (902) 660-5340
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SLEEP SERVICE REFERRAL: FAX TO (902) 660-5343

Patient Information

Name: ______________________________ DOB: __________________________

Phone: ______________________________ HCN: __________________________

Cell: ______________________________ Gender: Male / Female

Symptoms

- ❑ Snoring
- ❑ Witnessed apneas
- ❑ Daytime fatigue
- ❑ Daytime sleepiness

Associated Conditions

- ❑ Chronic Pain
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Diabetes
- ❑ Anxiety / Depression
- ❑ GERD / Reflux
- ❑ Overactive bladder
- ❑ Stroke

Medications / Other considerations

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Requested Service

- ❑ Home sleep study with interpretation
- ❑ CPAP trial (auto titration protocol)

Referring Physician

Physician Name: ___________________________ Phone: _________________________

Provider Number: ___________________________ Fax: _________________________

Street Address: ___________________________ City: _________________________

Postal Code: ___________________________

Signature: _________________________________ Date: __________________________

Sleep well.... Feel well... Live well!

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