Referral for Level III Home Sleep Study

Patient Name: ______________________________

PHN: ____________________ DOB: ______________

Home Phone: ______________ Work Phone ______________

Cell: ____________________ EMAIL ____________________

ADDRESS: ____________________ CITY: ______________ PC: __________

SYMPTOMS:

○ snoring ○ fatigue ○ witnessed apneas ○ A-Fib ○ hypertension ○ other ____________

Name of Referring Physician: ____________________

PH: ____________________ FAX: ______________

Please Fax RX for Home Sleep Study to 604-987-5336

RX Level III Home Sleep Study

DATE: ____________

______________________________ ______________

Physician Signature **Billing number**

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Office Stamp

Dr. Sharnell Muir

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