REFERRAL FOR ORAL APPLIANCE THERAPY

Patient Name____

PHN_______________ Date of Birth_____________ Email________________________________

Pt Phone__________________ Pt Cell________________

Address_______________________________________City_______________ Postal Code________

Family Physician_________________________ Phone_______________ Fax___________________

Sleep Physician_________________________ Phone_______________ Fax___________________

Office Location Option. We will contact the patient to schedule their preferred location. Please check location below.

PLEASE FAX TO 604-987-5336

Dx testing ___HST ___PSG OR ___is Required
(Please enclose a copy of previous study and diagnosis if avaliable)

Trialed CPAP Yes/No Wears CPAP Yes/No CPAP Intolerant Yes/No

TREATMENT PRESCRIPTION FOR ORAL APPLIANCE THERAPY

Physician Name________________________ **Physician Signature**__________________________

Billing #________________

PATIENT'S PREFERRED LOCATION:

_____ NORTH VANCOUVER

_____ VICTORIA

_____ DUNCAN

_____ NANAIMO

_____ COURTENAY

____

OFFICE STAMP

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