



## REFERRAL FOR LEVEL III HOME SLEEP STUDY

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_  
PHN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Pt Email \_\_\_\_\_  
Pt Phone \_\_\_\_\_ Pt Cell \_\_\_\_\_ Pt other \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
(if other than Family Physician)

**Please Fax or Email to:**

**604-587-5886 (Surrey) [infosurrey@sleepbetterlivebetter.ca](mailto:infosurrey@sleepbetterlivebetter.ca)**

**604-987-5336 (North Van) [info@sleepbetterlivebetter.ca](mailto:info@sleepbetterlivebetter.ca)**

**Patient symptoms and/or Medical Comorbidities:**

Hypertension  Cardiac Disease  Diabetes  Excessive Daytime Sleepiness  Fatigue  
 Depression  Snoring  Witness Apneas  Previous DX Sleep Apnea

### Prescription for Home Sleep Testing ( Level III HSAT)

Please discuss results with patient and provide to my office  
 Please provide testing results to my office

Referring Physician Signature \_\_\_\_\_

Billing number \_\_\_\_\_

Office stamp

**Dr. Sharnell Muir**  
*Sleep Better Live Better*

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