



## REFERRAL FOR ORAL APPLIANCE THERAPY

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

Consultation only  Consultation and Therapy if appropriate

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

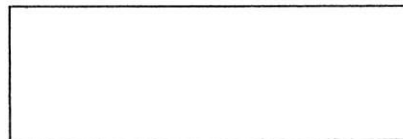
Hypertension  Cardiac Disease  Diabetes  Excessive Daytime Sleepiness  Fatigue  
 Depression  Snoring  Witness Apneas  Previous DX Sleep Apnea  
 Previous CPAP  CPAP Intolerance  Wears CPAP would like alternative for travel etc.

### **Prescription for Oral Appliance Therapy**

**Please provide a custom oral appliance for the management of this patient's  
Sleep Disordered Breathing (Snoring and/or Sleep Apnea).**

Referring Dr. Signature \_\_\_\_\_

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



Office stamp

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

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