Avant Respiratory

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SLEEP DISORDER REFERRAL FORM

PATIENT INFORMATION

LAST NAME | FIRST NAME | BIRTH DATE (D/M/Y)

GENDER | HEALTH CARD # | PHONE #

SERVICE REQUESTED

☐ **APNEA FAST TRACK™** – Level 3 (in home) sleep study with interpretation followed by APAP therapy and/or sleep medicine consultation as indicated or recommended.

☐ **SLEEP MEDICINE CONSULTATION** – Physician consultation and sleep testing as indicated.

☐ **LEVEL 3 SLEEP STUDY** – In home diagnostic study only.

☐ **PAP THERAPY RE-ASSESSMENT** – Already diagnosed with sleep apnea and using PAP therapy.

SYMPTOMS & MEDICAL HISTORY

☐ **Snoring**	☐ **Insomnia**	☐ **Hypertension**	☐ **Mood Disorder**	☐ **CHF**
☐ **Witnessed Apneas**	☐ **RLS**	☐ **Diabetes**	☐ **Depression**	☐ **Cardiac Arrhythmia**
☐ **Excessive Daytime Fatigue**	☐ **GERD**	☐ **COPD**	☐ **Chronic Pain**	☐ **Stroke**

ADDITIONAL INFORMATION:

REFERRING PHYSICIAN or NP INFORMATION

NAME

BILLING #

ADDRESS

CITY | POSTAL CODE

PHONE | FAX

OFFICE STAMP

SIGNATURE | DATE

PLEASE SIGN & FAX TO 902-407-4341