Avant Respiratory

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lethbridge@avantrespiratory.com

☐ **RED DEER**
Ph: 587-797-5376
Fax: 403 406 2007
reddeer@avantrespiratory.com

PATIENT INFORMATION

Name	
PHN	
Birth Date (M/D/Y)	Gender
Home #	Cell #
Address	
City	Postal Code
Email	
Height	**Weight**

REFERRING PHYSICIAN

Name	
PRAC ID	
Address	
City	Postal Code
Phone	
Fax	
Email	
Referral Request	☐ Urgent ☐ Routine

SLEEP SERVICES

SLEEP APNEA DIAGNOSTICS*

☐ Level 3 - Home Sleep Apnea Testing
☐ Level 1 - In-Lab Polysomnography and Consult

SLEEP APNEA TREATMENT

☐ APAP/PAP Therapy
☐ APAP/PAP Therapy Re-assessment

Reason for Referral:

☐ Snoring
☐ Witnessed Apneas
☐ Conditions of Excessive Sleepiness
☐ Other:
☐ Insomnia
☐ Frequent Awakenings
☐ Restless Legs Syndrome
☐ Parasomnia

_____

_____

MEDICAL HISTORY

☐ Mood Disorder
☐ Hypertension
☐ Stroke
☐ CHF
☐ Cardiac Arrhythmias
☐ Chronic Pain
☐ Sleep Apnea
☐ **Previous Test (please include)**

OXYGEN / RESPIRATORY SERVICES

OXYGEN

☐ OXYGEN THERAPY
(includes ABG, PFT, HSAT, Exertional Walk Test as per AADL)
☐ Maintain SpO >89%
☐ _____ LPM _____ hrs/day
☐ PALLIATIVE OXYGEN THERAPY
Diagnosis: _____
_____
☐ IN HOME OXYGEN ASSESSMENT

PULMONARY FUNCTION TESTING**

☐ COMPLETE PFT
(Spirometry, Diffusing Capacity, Lung Volumes)
☐ Arterial Blood Gas (ABG)
☐ PaO2<60mmHg Start O2

*Sleep Apnea Diagnostics completed by CPSA Accredited Sleep Lab **Pulmonary Function Testing completed by CPSA Accredited PFT Lab

PHYSICIAN SIGNATURE: _____ DATE: _____