SLEEP TESTING AND CONSULTATION REQUISITION

Please fax referrals to 587-200-7441

Patient Information

Today's Date _____

Patient Info: _____

Patient Name *Date of Birth* *Gender* *Alberta Healthcare Number (PHN/ULI)*

Parent Info: _____
(if patient is a child) *Parent Name* *Parent Relationship to Child*

Contact: _____
Circle Preferred *Home #* *Cell #* *Email*

Referring Doctor/Clinic

Phone: _____ Fax/Email: _____

_____
Doctor Signature *Doctor Name* *Doctor Prac-ID* *Clinic Name*

_____ _____
Street/Mailing *City* *Province* *Postal Code*

We are referring this patient for:

Adult sleep diagnosis and consultation

□ *Includes diagnostic testing, official diagnosis from a board certified sleep physician, and referral for treatment as indicated*

□ Please refer back for treatment/management

Pediatric sleep testing and consultation

□ *Includes diagnostic testing, official diagnosis from board certified sleep physician, and consultation with the patient with referral for treatment as indicated*

□ Please refer back for treatment/management

Other Notes: