MedSleep
+ LUNG FUNCTION

☐ **CALGARY**
Phone: 403-254-6400
Fax: 403-254-6403
Email: calgary@medsleep.com

☐ **EDMONTON**
Phone: 780-487-5333
Fax: 780-487-3045
Email: edmonton@medsleep.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

☐ SLEEP APNEA DIAGNOSIS & TREATMENT
(May include Level 3 (HSAT), Consultation, CPAP Therapy as indicated)
☐ SLEEP MEDICINE CONSULTATION
☐ POLYSOMNOGRAPHY
(Level 1 Sleep Study and Consult as indicated)
☐ CPAP 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)**

PULMONARY FUNCTION TESTING

☐ COMPLETE PFT
(Spirometry, Diffusing Capacity, Lung Volumes)
☐ SPIROMETRY (Pre/Post Bronchodilator Admin)
☐ MIPS/MEPS
☐ Arterial Blood Gas (ABG)
☐ PaO2<60mmHg Start O2

Reason for Testing:

☐ Cough
☐ Pre/Post Op Assessment
☐ Others:
☐ Asthma/COPD
☐ Routine Follow Up

_____

_____

OXYGEN (Completed by AvantSleep & Respiratory)

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

CURRENT MEDICATIONS/ADDITIONAL INFORMATION

PHYSICIAN SIGNATURE: _____ DATE: _____