MedSleep + LUNG FUNCTION

☐ **CALGARY**
Phone: 403-254-6400
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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

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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

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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: ______________________