SLEEPLIFE

ansr.ca/sleeplife

PATIENT REFERRAL

Fax to: 902-455-2677
Email to: info@sleeplifeatlantic.com

PATIENT INFORMATION

FIRST NAME | LAST NAME | DATE OF BIRTH (DD/MM/YYYY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

PHONE # (CELL) | PHONE # (HOME) | EMAIL ADDRESS

PATIENT DIAGNOSIS & CO-MORBIDITIES *(If known, check off all that apply)*

☐ UARS	☐ HYPERTENSION	☐ ATRIAL FIBRILLATION
☐ MILD OSA	☐ DIABETES	☐ PREVIOUS STROKE
☐ MODERATE OSA	☐ DEPRESSION	☐ PTSD
☐ SEVERE OSA	☐ ANXIETY	☐ OTHER CARDIAC DISEASE
	☐ GERD	☐ _____
	☐ RLS	☐ _____
	☐ COPD	

Additional Information:

BRIEF CLINICAL HISTORY

REFERRAL REQUEST

☐ SLEEP STUDY TESTING	☐ FOLLOW UP CARE *(CURRENTLY ON DEVICE)*
☐ CPAP MACHINE & MASK *(WITH 1 MONTH TRIAL)*	☐ OTHER:
☐ REPLACEMENT CPAP MACHINE & MASK	

PREFERRED LOCATION

☐ Fall River, NS	☐ Windsor, NS	☐ St. John's, NL
☐ Bedford NS (*SLEEP STUDY ONLY)*	☐ Sydney NS	☐ Port Aux Basques, NL
	☐ Fredericton, NB	

PHYSICIAN / NP INFORMATION

PHYSICIAN/NP NAME | SIGNATURE

LICENCE # | DATE