OXYLIFE
SLEEP & BREATHING CENTRE

# Respiratory Services Requisition

REGISTERED cpap PROVIDER
REGISTERED CANADIAN PROVIDER

## PATIENT INFORMATION

DATE: _____

Last Name _____ Address _____ City: _____

First Name _____ _____ PC: _____

Health Card No. _____ _____ Phone: _____

Sex: ☐M ☐F DOB: _____ _____ Email: _____

## SLEEP

☐ Sleep Apnea Diagnostics (Level III)

☐ If positive screen for OSA, proceed to Auto CPAP Trial

***Prescription:***

CPAP to treat OSA with pressures between 4--16cm $H_20$ indefinitely

***or***

Specify Pressure Range

_____ to _____ cm $H_20$

## OXYGEN

☐ Oxygen Assessment

☐ Oxygen Therapy

Oxygen services available to patients with Extended Health Benefits, or private payees.

☐ CPAP RE-ASSESSMENT

☐ BI-PAP THERAPY

Medical Hx/Notes _____

_____

## Referring Physician/Practitioner Information or Clinic Stamp

Name _____ Date _____

Signature _____ Clinic _____

Prac ID _____ Phone: _____ Fax: _____

1964 13th Avenue, Prince George, BC V2K 1R9
Phone 250-563-1887 | Fax 250-563-1837
www.sleepapneabc.ca | oxylifepg@gmail.com

We will contact the patient directly to book the appointment. Thank you for your referral.