OXYLIFE
SLEEP & BREATHING CENTRE

Respiratory Services Requisition

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: ____________

691 Seymour Street, Kamloops, BC V2C 2H1
Phone 250-828-6726 | Fax 250-828-1833
www.sleepapneabc.ca | oxylifebc@gmail.com

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