



Patient's Label

SLEEP AND RESPIRATORY REFERRAL

FAX TO 1 866-812-0202 or PHONE 1 800-637-0202
www.vitalaire.ca

Patient information

Last Name:		First Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			
City:	Prov:	Postal Code:	
Phone:	PHN#	DOB: MM/DD/YYYY	
Alternate Contact Name:		Alternate Contact Phone:	
Diagnosis:			

Sleep Apnea Testing and Treatment

DIAGNOSTICS

Level 3 Sleep Study Interpretation
 Level 3 Sleep Study & initiate CPAP therapy if test results indicate Obstructive Sleep Apnea (APAP 4-20 cmH2O)
 Initiate CPAP therapy (requires previous diagnosis)
Approved CPAP provider for Ministry of Citizens' Services and the Ministry of Social Development and Poverty Reduction

<p>STOP BANG QUESTIONNAIRE:</p> <p><input type="checkbox"/> Snoring - loud and disruptive <input type="checkbox"/> Tired - Excessive daytime sleepiness <input type="checkbox"/> Observed - Breathing pauses of choking/gasping during sleep <input type="checkbox"/> Pressure - Treated for High Blood Pressure <input type="checkbox"/> Body Mass Index > 35kg/m2 <input type="checkbox"/> Age older than 50 <input type="checkbox"/> Neck size (>17" for men OR >16" for women) <input type="checkbox"/> Gender = male</p>	<p>Comorbidities</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> CHF <input type="checkbox"/> Other</p>
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Home Oxygen Therapy

Testing: Patients requiring home oxygen assessment for the Provincial Home Oxygen Program: refer to your local outpatient clinic for qualification testing.
Patients not meeting Home Oxygen Program qualifying criteria are eligible for Private Pay Option with physician Rx:
Rx: Initiate O2 therapy to maintain SpO2 > 89% or _____ LPM
VitalAire is the Primary Home Oxygen Program Provider in BC to the Provincial Home Oxygen Program
*** Oxygen Services provided on Vancouver Island by VitalAire's partner RHS**

Special Instructions

Physician/Referrer Name: _____
Physician Signature: (required) _____
Date: MM/DD/YYYY _____

Clinic Stamp