RESPIRATORY HOMECARE SOLUTIONS INC.

@ CBI HEALTH
100 Signal Road
Fort McMurray, AB T9H 5A3
Phone: 780.750.5838
Fax: 780.750.5839

RESPIRATORY REQUISITION FORM

SLEEP APNEA – PULMONARY DIAGNOSTICS – OXYGEN

PATIENT INFORMATION or PATIENT LABEL

Last Name _____ First _____ Sex ☐ M ☐ F

Address _____

City _____ Postal Code _____ Tephone # _____ (DAYTIME)

D.O.B _____ (MM/DD/YY) Health Card # _____

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☐ **Sleep Apnea Diagnostic Testing (Level III)**
CPAP Trial/Treatment, Oral Appliance, Spirometry
and/or referral to sleep specialist/PSG - if indicated.

☐ CPAP Re-assessment

☐ Oxygen Assessment (ABG as required)

Med Hx/Notes _____

Office Phone # _____ Office Fax # _____

Clinic Name _____ Date _____ (MM/DD/YY)

Referred by Dr: X _____ Physician/Practitioner Signature _____ Please Print Name _____ PRAC ID#

OPTIONAL CLINIC STAMP

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