



AvantSleep Victoria

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Please Fax Referral to: 250-391-8400

SERVICES REQUESTED

* Level 3 Sleep Study and Auto-PAP treatment
with heated humidifier and mask and/or
Sleep Medicine Consultation as indicated

Auto PAP Reassessment

PATIENT INFORMATION

Name _____
Health Care Number _____
Street Address _____
City/Town _____
Province _____ Postal Code _____

Gender M F
Height _____ Weight _____ Neck Size _____
Birth Date _____
Primary Contact Number _____
Secondary Contact Number _____
Email _____

SYMPTOMS

- Snoring
- Insomnia
- Witnessed Apneas
- Excessive Daytime Fatigue
- Excessive Daytime Sleepiness
- Restless Legs Syndrome
- Other _____

MEDICAL CONDITIONS

- MI/CAD
- Seizures/Epilepsy
- GERD
- Fibromyalgia
- Mood Disorder
- Anxiety Disorder
- Hypertension
- Diabetes
- Stroke
- Asthma/COPD
- Chronic Pain
- CHF
- Cardiac Arrhythmia
- Other _____

COMMENTS / MEDICATIONS

REFERRING PHYSICIAN

Physician _____
PRACID # _____
Street Address _____
City _____

Phone _____
Fax _____
Email _____
Postal Code _____

Signature _____

Date _____

PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.

* LEVEL 3 STUDY INTERPRETATION AND SLEEP MEDICINE CONSULTATION PROVIDED BY MEDSLEEP PHYSICIANS