AvantSleep

Please Fax Referral to:
(403) 254-6403

☐ **CALGARY SOUTH LOCATION**
Suite 4101 - 230 Eversyde Blvd SW
Calgary, Alberta T2Y 0J4
Phone: (403) 254-3585

☐ **CALGARY CROWFOOT LOCATION**
Suite 340 - 600 Crowfoot Crescent NW
Calgary, Alberta T3G 0B4
Phone: (403) 254-3585

☐ **CALGARY CENTRE LOCATION**
Suite 203 - 5809 MacLeod Trail SW
Calgary, Alberta T2H 0J9
Phone: (403) 254-3585

TEST REQUESTED

☐ *Level 3 Sleep Study (to include APAP Treatment and/or Sleep Medicine Consultation if indicated)

☐ Auto PAP Reassessment

PATIENT INFORMATION

Name _____ Gender ☐ M ☐ F

Health Care Number _____ Primary Phone _____

Street Address _____ Secondary Phone _____

City/Town _____ Email _____

Province _____ Postal Code _____

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 _____ Phone _____

City/Town _____ Fax: _____

Province _____ Clinic Email _____

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***