



Unit 102  
51 Inglewood Drive  
St. Albert Alberta  
T8N 4E7

# SLEEP APNEA TESTING REQUISITION

AFFIX PATIENT LABEL HERE OR FILL OUT

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Daytime Telephone: \_\_\_\_\_ Birth Date (DD/MM/YY): \_\_\_\_\_ ULI: \_\_\_\_\_

### Sleep Apnea Diagnostic Testing (Level III)

Based on testing results, the following may be offered

- CPAP Trial / Treatment
- Snoring Assessment
- Oral Appliance Assessment / Referral
- CPAP Re-Assessment

## MAXIMUM SLEEP CARE

Fax: 780-569-5253  
Phone: 780-569-5252

Medical History/Reason for Referral:  
\_\_\_\_\_  
\_\_\_\_\_

Referring Clinic: \_\_\_\_\_ Date: \_\_\_\_\_  
Referring Dr: \_\_\_\_\_ Practice ID: \_\_\_\_\_  
Printed Name Signature  
Referring Clinic Phone: \_\_\_\_\_ Referring Clinic Fax: \_\_\_\_\_