SNORING
& Sleep Apnea Clinics

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Sleep Disorders and Orofacial Pain

PLEASE FAX REFERRALS TO

250-869-0071

Serving the Okanagan Valley

Today's date _____

Patient name _____ Home Phone _____

DOB _____ Work Phone _____

Email _____ Cell Phone _____

REFERRAL FOR ASSESSMENT

Your patient's concerns? _____

_____

Your concerns? _____

Has your patient had a sleep test?	Yes ☐	No ☐
Has your patient worn CPAP?	Yes ☐	No ☐
Is your patient considered CPAP Intolerant	Yes ☐	No ☐

Referring Dentist/Hygienist _____

Fax # _____

Signature _____

Dentist/Hygienist/Office or Clinic Stamp