Patient Referral Form

ARIA MD
Sleep Centre

Patient Information:

(place patient label here)

Home Sleep Apnea Test Referral Reason: (please check boxes that apply):

- ☐ *Excessive snoring*
- ☐ *Apneas*
- ☐ *Increased BMI*
- ☐ *Morning headaches*
- ☐ *Daytime somnolence*
- ☐ *Hypertension*
- ☐ *Diabetes*
- ☐ *Other:* _____

Patient Contact Information

Phone (main): _____ *Alternate Phone:* _____

Referring Physician Order: **We do not accept pediatric referrals.*

- ☐ *Adult Home Sleep Apnea Test (HSAT) additional:* _____
- ☐ *Adult Home Sleep Apnea Test and ENT referral (must include consult letter)*

Referring Physician: _____ *Phone:* _____

Signature: _____ *Fax:* _____

Date: _____

For *Edmonton* referrals please fax to: *780-784-1354*

For Calgary referrals please fax to: 403-457-2400

☐ **Edmonton Downtown** ☐ **Edmonton South** ☐ **St. Albert** ☐ **Calgary**

EDMONTON DOWNTOWN

10202 - 111s t NW
P: 780 - 784 - 1353
F: 780 - 784- 1354

EDMONTON SOUTHSIDE

110 - 6925 Gateway Blvd NW
P: 780 - 809 - 0882
F: 780 - 809 - 2799

ST.ALBERT

103 - 225 Carleton Dr.
P: 780 - 591 - 2742
F: 780 - 591 - 2744

CALGARY

106 - 506 71 Ave SW
P: 403 - 300 - 2744
F: 403 - 457 - 2400