Sleep Referral

Home sleep testing · CPAP care and support

KV Referral Fax	Riverview Referral Fax	Sussex Referral Fax
506-847-1882	**506-979-1701**	**506-434-0637**

Referral date: _____

Patient label may be placed over this section

Patient's name: _____

Date of birth: ____ / ____ / ____ (DD / MM / YYYY) **Medicare #:** _____

Phone: _____ **Email:** _____

Comorbidities *check all that apply*

- ☐ Hypertension
- ☐ Diabetes
- ☐ Atrial fibrillation
- ☐ HF or MI
- ☐ Stroke / TIA
- ☐ BMI > 35
- ☐ Depression / anxiety
- ☐ COPD / asthma
- ☐ GERD

Notes: _____

Physician-interpreted home sleep study. **No charge to your patient.**

☐ **Home sleep study.** If the physician-interpreted study indicates sleep apnea, please provide CPAP/BiPAP, humidifier, mask, battery and trial, with initial and ongoing titration, and forward results.

- ☐ *Please do not set up on PAP until I have reviewed the report.*

☐ **Already on CPAP.** Please assess and support with mask, equipment, and initial and ongoing titration. *Attach previous sleep study if available.*

☐ **Other:** _____

Signature: _____ **Date:** _____

Referring provider and clinic fax: stamp or label

KV
154 Hampton Rd – Unit 109
Rothesay, NB · 506-847-5100

Riverview
631 Pinewood Rd – Unit 102A
Riverview, NB · 506-405-0700

Sussex
20 Kennedy Dr – Unit 6
Sussex, NB · 506-434-7667

The first visit is just the beginning.
We stay with your patient, and keep you posted.

Better Sleep. Better You.