REST EASY ALBERTA

11040 - 51 Ave. NW
Edmonton, AB T6H 0L4
Tel No. 780 - 800 - 1450
Fax: 780.244.7378

Referral

Patient Information

Last Name: Label Here
First Name:
DOB (YY/MM/DD):
☐ **Male** ☐ **Female** ☐ **Other**
Home Address:
Edmonton
AHC Number:
Preferred Contact Number: ( ) -
Alternate Number: ( ) -
Date Referral Sent:

Referring Clinic Information

Clinic Name: Label Here
Referring Physician:
Practitioners ID #:
When contacting this clinic please call:
Contact Number: ( ) -
Contact Name:
Primary Care Physician if different than above:
Physician Name:
Fax: ( ) -
Phone: ( ) -

Sleep Services

- ☐ Home Sleep Testing
  Choose one for extra monitoring
  ☐ Bruxism ☐ Restless Leg/PLM ☐ ECG monitoring
  ☐ PAP Titration with overnight oximetry
- ☐ Sleep Consult (For Stroke, Severe Obesity, Complex Sleep Disorder)
- ☐ APAP/CPAP Therapy: _____ cm H2O to _____ cm H2O
- ☐ Other

Respiratory Services

- ☐ Full (PFT) Pulmonary Function Test
  Spirometry (PRE & POST Bronchodilator) Plethysmography Lung Volumes (TGV, TLC, RV, Airway resistance), Diffusion Capacity (DLCO)
- ☐ Spirometry Pre and Post Bronchodilator Only
- ☐ Spirometry and Diffusion Capacity (DLCO) Only
- ☐ PFT with PULMONARY CONSULT

Medical Conditions/Symptoms

- ☐ Hypertension
- ☐ Neuromuscular Disease
- ☐ Diabetes
- ☐ Depression
- ☐ Anxiety
- ☐ CHF
- ☐ Asthma
- ☐ Cardiac Arrhythmias
- ☐ Chronic pain
- ☐ COPD
- ☐ Chronic Cough
- ☐ Dyspnea
- ☐ Fibrosis
- ☐ Infection
- ☐ Wheeze
- ☐ Post Covid
- ☐ Others

Sleep Related Concerns

- ☐ Morning Headaches
- ☐ Frequent Awakenings
- ☐ Witnessed Apneas
- ☐ Snoring
- ☐ Excessive Daytime Sleepiness
- ☐ Drowsy Driving
- ☐ Sleep Walking
- ☐ Insomnia
- ☐ Mouth Breathing

Reason for referral

Dr. Signature

**Considered a valid prescription when signed by a physician*

Breathe Easy, Rest Easy.

11040 - 51 Ave. NW
Edmonton, AB T6H 0L4
Tel No. 780 - 800 - 1450
Fax: 780.244.7378

Name: Age:

Date of Birth: ☐ Male ☐ Female

STOP-BANG QUESTIONNAIRE

Screening

Is it possible that you have ...
Obstructive sleep apnea (osa)?

Please answer the following questions below to determine if you might be at risk.

Yes	No	
☐	☐	**Snoring?** Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
☐	☐	**Tired?** Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?
☐	☐	**Observed?** Has anyone observed you stop breathing or choking/gasping during your sleep?
☐	☐	**Pressure?** Do you have or are being treated for high blood pressure?
☐	☐	**Body mass index** more than 35 kg/m2?
		Body mass index calculator
		cm / kg ☐ inches / lb ☐
		Height: _____ Weight: _____ **Calculate BMI** _____
☐	☐	**Age** older than 50?
☐	☐	**Neck size** large? (Measured around adams apple) Is your shirt collar 16 inches / 40cm or larger?
☐	☐	**Gender** = male?

Total _____

For general population

Osa - low risk: yes to 0 - 2 questions

Osa - intermediate risk: yes to 3 - 4 questions

Osa - high risk: yes to 5 - 8 questions

Or yes to 2 or more of 4 stop questions + male gender

Or yes to 2 or more of 4 stop questions + bmi > 35kg/m2

Or yes to 2 or more of 4 stop questions + neck circumference 16 inches / 40cm