Fax 1-250-701-0425

1950 Fort Street, **Victoria**
5440 Trans Canada Hwy, **Duncan**
2210 Northfield Rd, **Nanaimo**
5016 Argyle St, **Port Alberni**

Phone 1-250-701-0424

Patient Name: ________________________________

Date ____________________ Phone _______________

PHN ____________________ D O B _______________

Address _____________________________________

Diagnosis ____________________________________

Sleep Diagnostics

- ❑ Overnight Oximetry Study on **Room Air**
- ❑ Overnight Oximetry Study on **PAP Therapy**
- ❑ Level 3 Sleep Diagnostic Study – (Stardust®)
- ❑ ____________________________________

Sleep Apnea Therapy

- ❑ PAP Therapy – *Diagnosis*: *Obstructive Sleep Apnea*
- ❑ Pressure at ___________ cm H_2O
- ❑ Pressure at RRT discretion: ________ *(please initial)*
- ❑ Add Heated Humidification

Oxygen Therapy

- ❑ O2 at __________ L / minute - Duration ___________
- ❑ ____

Physician Signature ___________________________

Physician Name

MSP

Phone

Fax

0507