Medigas
Manitoba Limited
RESPIRATORY WELLNESS CENTRE

150 McPhillips St., Winnipeg, MB R3E 2J9
[p] 204-786-CPAP (2727) **[Toll Free]** 1-855-766-7388 **[f]** 204-786-1972
[e] CPAP@medi-gas.com **[w]** www.medi-gas.com

HOME SLEEP APNEA TEST REFERRAL

☑ OSA Level 3 Overnight Sleep Test ☑ CPAP Auto Titration Trial when sleep test indicates trial is required

PATIENT INFORMATION

Last Name:	**First Name:**	
Address:		
Home Phone:	**Work Phone:**	**Cell Phone:**
Email:		
Birth Date (DD/MM/YYYY):	**Height (cm):**	**Weight (kg):**
Accessibility Requirements:		
Referral Reason (insert below):	**Sleep Symptoms/History:**	
	☐ Snoring ☐ Witnessed apnea ☐ Daytime sleepiness ☐ Frequent wakening	☐ Morning headaches ☐ Hypertension ☐ Family history ☐ Nocturia
Comments – Relevant Medical History and Medications		
NOTE: **Referrals with Brain Injury, Stroke, COPD, Coronary Heart Disease, or Congestive Heart Failure benefit most from an in-hospital sleep test.**		

REFERRING PHYSICIAN INFORMATION

Name:	**Address:**	
Phone:	**Fax:**	**Email:**

Physician Signature

Date