

SLEEP DISORDERS REFERRAL FORM

Surrey Sleep Clinic & Laboratory

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www.surreysleepclinic.com

New address effective August 2019

(PLEASE FAX FORM TO 604-372-0134)

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Refer	ring Physician Na	me:					_	MSP	#		
Phone					Fax	·					
Clinic A	Address								_ City _		
Please	Choose:										
	Sleep Medicine (Consultation wit	h Dr.	A. S. Minl	has or	r Delegate	<u>:</u>				
	Overnight Polysomnography (Level 1) – Please provide HSAT report, if available										
	Overnight Polyso	mnography (Le	vel 1) – Please p	orovide	HSAT repor	rt, if a	wailable			
						_	-		WT, M	SLT & other i	n-lab tests)
	(Sleep Medicine con.	sult is required for L	evel 1	Polysomnog	graphy,	, CPAP or D	ental	titration, M		SLT & other i	n-lab tests)
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	(Sleep Medicine con. Level 3 Home Sle	sult is required for L	evel 1 (Rapi	Polysomnog	graphy, o sleep 1	, CPAP or D	ental	titration, M		SLT & other i	n-lab tests)
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