Reset

THOMPSON RIVERS UNIVERSITY

Center for Respiratory Health and Sleep Science
Respiratory Therapy Program

PATIENT REFERRAL REQUISITION

Patient Name (or label): **DOB:** MM/DD/YY

Address: **City:** **Postal Code:**

Sex: ☐ Male ☐ Female **Age:** **PHN#:**

Home #: **Cell/Work #:** **Email:**

STOP-Bang Questionnaire:	**Co-Morbidities:**
☐ **S** noring - loud and disruptive ☐ **T** ired - Excessive daytime sleepiness ☐ **O** bserved - Breathing pauses of choking/gasping during sleep ☐ **P** ressure - Treated for High Blood Pressure ☐ **B** ody Mass Index > 35kg/m2 ☐ **A** ge older than 50 ☐ **N** eck size (>17" for men OR >16" for women) ☐ **G** ender = male	☐ Hypertension ☐ Diabetes ☐ Metabolic Syndrome ☐ CHF ☐ COPD ☐ Other: _____

Rx **Please select from the following:**

☐ **24hr Ambulatory Blood Pressure Monitoring**	

Special Instructions:

Referring Physician/Nurse Practitioner Name & MSP#: _____ **Phone #:** _____ **Fax #:** _____	**Clinic Name/Address (or Stamp):**

Physician/NP Signature: **Date:** M/D/Y

Thank you for supporting the TRU Respiratory Therapy Sleep Clinic

Fax Requisition to TRU Sleep Clinic: (250) 371-5771

859 College Drive, Ken Lepin Science Building, Kamloops, BC V2C OC8 Phone: (250) 371-5952