Saint John Office
660 Rothesay Avenue, Unit J
Ph: **506-638-8401**
Fax: **506-638-8409**

Moncton Office
25 Gorge Road, Unit 2
Ph: **506-382-8544**
Fax: **506-382-5893**

Quality Respiratory Care

Fredericton Office
900 Hanwell Road, Unit 20
Ph: **506-453-7810**
Fax: **506-453-7807**

Miramichi Office
135 Henry Street, Suite 2
Ph: **506-622-9099**
Fax: **506-622-8246**

Sussex Office
21 Winter Street, Unit 2
Ph: **506-433-6117**
Fax: **506-433-5747**

Woodstock Office
100 Jones Street, Suite 200
Ph: **506-325-0014**
Fax: **506-325-0662**

Quispamsis Office
19 Pettingill Road, Suite 2
Ph: **506-847-3001**
Fax: **506-849-8716**

Sleep Disorder Screening Program

Please see _____ *Tel #* _____

OSA Screening and Diagnostics; ☐ *Home sleep apnea testing*

Once Testing is complete;
☐ *If positive, proceed with CPAP therapy as follows,*
☐ *Do not proceed with therapy, I will contact you for further instructions / orders if required*

CPAP Therapy;
☐ *Treat with auto CPAP with follow-up oximetry and device download to verify efficacy*
☐ *Specified pressure* _____ *with follow-up oximetry and device download to verify efficacy*

Length of Use;
☐ *Indefinite / Long Term*
☐ *Follow up testing as requires for duration of use*

Please select;

☐ *I want screening tests sent to Dr.* _____ *for formal interpretation*

☐ *Send the test data back to me for interpretation*

☐ *Send the test data to any specialist for formal interpretation*

Please note that many insurance companies now require physicians to list any pre-existing co-morbidities that may be complicated by sleep apnea in order to approve CPAP claims. Please select all that apply:

☐ **Diabetes**
☐ **AFib**
☐ **Anxiety/Depression**
☐ **COPD**
☐ **Hypertension**
☐ **CHF**
☐ **Other Cardiac Disease**
☐ **Other:**_____

Physician Signature _____ *Date*_____