



Sleep Services Requisition
F: 1(877) 830-0437 | P: 1(866) 537-0350 | E: refer@resolvesleep.com

Patient Information		
Last Name:	First Name:	DOB (mm.dd.yy):
Address:		
City:	Province:	Postal Code:
Home Tel:	Mobile:	HCN:
Email:		

Requisition

- Sleep Education Session
- PAP Therapy
- Oral Appliance Therapy
- Cognitive Behavioral Therapy for Insomnia
- Oxygen

PAP Therapy Order	
APAP/CPAP Therapy	AHI:
Mode: <input type="checkbox"/> APAP <input type="checkbox"/> CPAP	
CPAP Pressure: _____ cmH ₂ O	
Min APAP Pressure: _____ cmH ₂ O	
Max APAP Pressure: _____ cmH ₂ O	
Ramp <input type="checkbox"/> Auto <input type="checkbox"/> Off Min: _____	
Download at: <input type="checkbox"/> 1 week <input type="checkbox"/> 1 month <input type="checkbox"/> 90 days	
EPR:	
Mask details:	Tubing/Accessories
<input type="checkbox"/> Nasal Mask <input type="checkbox"/> Nasal Pillows Mask	<input type="checkbox"/> Heated Tubing <input type="checkbox"/> Filters
<input type="checkbox"/> Full Face Mask <input type="checkbox"/> Patient Choice	<input type="checkbox"/> Humidifier Chamber <input type="checkbox"/> Chin Strap
<input type="checkbox"/> Check Mask Fit	Other: _____

Prescribing Physician	
Name:	Billing Number:
Address:	
Telephone:	Fax:
Email:	

Comments:

SIGNATURE:

DATE: