The Snore Centre
201-5540 Windermere Blvd NW
Edmonton, AB, T6W 2Z8
P: 780-761-6671
F: 780-761-6673
E: Windermere@thesnorecentre.com

Sleep-Disordered Breathing Consultation Form

F: 780.761.6673

Date: ______ / ______ / ______
Day Month Year

Patient Information or Patient Label

Last Name ______________________
First Name ______________________
Address ______________________
Town/City ______________________
Postal Code ______________________
Date of Birth (mm/dd/yyyy) ______________________

Home Phone ______________________
Cell Phone ______________________
Business Phone ______________________
Email ______________________
Preferred Method of Contact ______________________
Gender M ☐ F ☐

Referring Doctor or Office Label

Clinic Name ______________________
Address ______________________
Phone ______________________
Fax ______________________

Dr. ______________________

Signature ______________________

Reason(s) for this Consult

- ☐ Snoring
- ☐ Breathing pauses or choking episodes at night
- ☐ TMD Consultation
- ☐ Pediatric Sleep & Orthodontics
- ☐ CPAP non-compliance
- ☐ MATRx Plus testing

Other Conditions

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ History of recent weight gain
- ☐ Depression
- ☐ Other: ______________________

Additional Comments and Patient History

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Office Use Only

Patient Contacted: ______ / ______ / ______
Day Month Year

Form Received: ______ / ______ / ______
Day Month Year

Appointment Date: ______ / ______ / ______
Day Month Year

Patient was reminded to arrive **30** minutes before the appointment and bring:

- ☐ List of medications
- ☐ Any previous sleep studies / reports
- ☐ Any relevant information, such as CPAP report, etc.

Notes: ____

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