MERRELL CLINIC

Stop snoring. Start sleeping.

REFERRAL FOR (please check one or more boxes below)

- ☐ In-Home Sleep Apnea Screening Study
- ☐ In-Home CPAP Pneumotach study
- ☐ Consultation
- ☐ Dental Appliance - CPAP Intolerant

Date (yy mm dd) ☐☐☐☐☐☐

EDMONTON
Avalon Dental
4910 Roper Road NW, Edmonton, AB T6B 3T7
phone: 780.424.SNOR (7667) • fax: 780.432.0584
edinfo@merrellclinic.com

CALGARY
Northwest Dental - Dalbrent Plaza
#206, 3604 - 52 Ave NW, Calgary, AB T2L 1V9
phone: 403.244.SNOR(7667) • fax: 888.310.3977
calinfo@merrellclinic.com

TOLL FREE 888-887-6674

Patient Information

Last Name: _____ Home #: _____

First Name: _____ Bus #: _____

Address: _____ Cell #: _____

Town/City: _____ Email: _____

Postal Code: _____ Date of Birth: _____yy _____mm _____dd

Sex: ☐ Male ☐ Female

❶ HISTORY SLEEP PROBLEM

- ☐ Snoring
- ☐ Witnessed Apneas
- ☐ Excessive Daytime Sleepiness
- ☐ Nocturia
- ☐ Insomnia
- ☐ Frequent Awakenings
- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movement Disorder
- ☐ Symptomatic in Spite of CPAP Use
- ☐ CPAP Intolerant
- ☐ Shift Work
- ☐ Other _____

❷ MEDICAL CONDITIONS

- ☐ MI/CAD
- ☐ Diabetes
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ GERD
- ☐ Asthma/COPD
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Mood Disorder
- ☐ CHF
- ☐ Anxiety Disorder
- ☐ Cardiac Arrhythmia
- ☐ Hypertension

❸ MEDICATIONS

Name:	Condition:	Dosage:

❹ RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY

Physician Authorization (please print)

Name: _____ Clinic Name: _____

Signature: _____ Address: _____

Ph #: _____ Fax: _____

Office Use Only:

Appt. Date & Time: _____ Request Previous Studies: _____

Appt. Location: _____ Initial: _____

Other Notes: _____

www.merrellclinic.com