dr tara dental

P 780 665 3780 | E hello@drtaradental.com | W drtaradental.com

#8,1109 Summerside Dr SW, Edmonton, AB T6X 0H5 INSIDE SUMMERSIDE DENTAL

REFERRAL FORM - TREATMENT OF SNORING AND SLEEP APNEA

Patient _____ Date of Birth YYYY / MM / DD

Phone _____ Cell _____

Address _____

REASON FOR REFERRAL

☐ Snoring

☐ Obstructive Sleep Apnea
- ☐ Unable to tolerate CPAP
- ☐ Patient using CPAP (CPAP pressure: _____)

☐ Date of Last Sleep Study: _____

☐ Additional information: _____

_____

☐ Other: _____

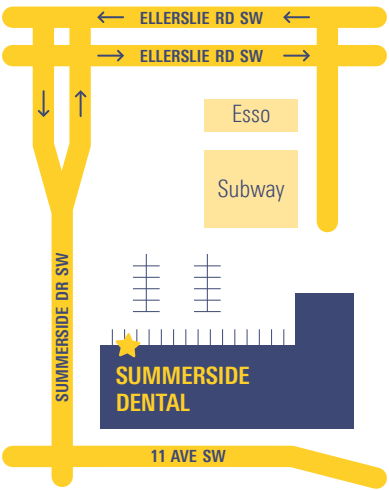
REFERRAL SOURCE INFORMATION

Referred by: _____

Phone: _____

Email: _____

Date: _____



★ *Dr. Tara Dental is located in Summerside Dental*

PLEASE EMAIL OR FAX THIS REFERRAL FORM AND YOUR SLEEP STUDY SUMMARY TO:

EMAIL hello@drtaradental.com

FAX 780.440.4288