

REFERRAL

Patient Name: _____

PHN: _____

Telephone: _____

Date of Birth: _____

Please fax this form to 604-876-7121.

INDICATION:

Please check as applicable:

- This patient has been referred to A.S. Minhas, MBBS, FRCPC, FAASM, for evaluation of symptoms related to sleep apnea.
- This patient has been referred to Wayne Halstrom, B.A., D.D.S. for treatment of Obstructive Sleep Apnea with a mandibular repositioning device.



As prescribed by:

Dr.'s Stamp Here

Date: _____

Physician Signature _____

CONTACT INFORMATION

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