REFERRAL FOR CONSULTATION & ASSESSMENT

Please Fax To 604-876-7121

Patient Name: ____________________________________ DOB DD/MM/YR): _____________

Phone Number: ____

PHN: __________________________ Today's Date ________________________

ASSESSMENT FOR MANDIBULAR REPOSITIONING DEVICE IN THE TREATMENT OF SNORING AND/OR OBSTRUCTIVE SLEEP APNEA.

_________________________________ _______________________________

REFERRING DENTIST - STAMP **SIGNATURE**

L. Wayne Halstrom **B.A., D.D.S., Dip.A.B.D.S.M., Dip.A.S.B.A.**

Diplomate American Board of Dental Sleep Medicine
Diplomate American Sleep & Breathing Academy
Adjunct Professor of Respiratory Therapy
Faculty of Science - Sleep Program, Thompson Rivers University

Central Reception Line: Tel 604-876-8993
www.drhalstrom.com

Dr. Halstrom
Sleep Apnea & Snoring Clinics

Administration Office
17335 - 59th Ave
Surrey, BC V3S 1N9

604-876-8993 Tel 604-876-7121 Fax
www.drhalstrom.com

SURREY - VANCOUVER
BURNABY - KAMLOOPS - KELOWNA
VICTORIA - PRINCE GEORGE