DR JASON CHAU SLEEP SURGERY REFERRAL

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☐ M ☐ F ☐ X

LAST Name: ____________________ **FIRST Name:** ____________________

DATE OF BIRTH:____________ **AGE:** ______ **PHONE #:** ____________________

FULL ADDRESS: (include city & postal code) ________________________________

PHN: ____________________ **E-MAIL** ____________________

(or patient label) ****If any of the above fields are missing, the referral will not be processed**

REFERRAL INFORMATION:

DIAGNOSIS:

- ☐ **OSA - Mild Mod Severe** *sleep study report (MUST be attached to complete referral)
- ☐ **UARS**
- ☐ **PRIMARY SNORING**
- ☐ **OTHER:** ________________________________

REASON FOR REFERRAL:

- ☐ **Primary Surgical Management**
- ☐ **Nasal Airway Optimization**
  - ☐ **Deviated nasal septum limiting CPAP use**
  - ☐ **Nasal Congestion**
- ☐ **Other:** ________________________________

CPAP DATA: (or attached CPAP report)

☐ Compliant ☐ On trial ☐ Intolerant ☐ Unwilling to try ☐ Not indicated

Current Pressure: ______ cmH2O **Mask:** ☐ Nasal ☐ OroNasal ☐ Full Face

CURRENT INVESTIGATIONS / TREATMENT TRIALED : ☐ Medical history attached on next page

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☐ Patient is aware they are being referred for SURGICAL consultation. CPAP and Oral appliance treatment has been reviewed as alternative treatment options.

☐ Patient has been informed to research upper airway surgery and to review our website in the meantime.

REFERRING PHYSICIAN INFORMATION **Referral Date:**____________________

Print Name:	Signature:
Physician Phone:	Physician Fax:
Physician Prac ID:	Physician Address:

Family Doctor (if different than referring): ________________________________