Saskatoon CPAP
#47 - 2105 - 8th Street East • Saskatoon • SK • S7H 0T8
phone: 306.974.0030 • *fax:* 306.974.0033 • *website:* saskatoon-cpap.ca • *email:* support@scscpap.ca

SCS SASKATOON CPAP SERVICES REFERRAL FORM

PATIENT INFORMATION

Name:

Health Card Number:

Date of Birth:

Height:

Weight:

Phone Number:

Address:

Gender:

Pronouns:

REFERRAL DETAILS

Please select one reason for referral

REFERRAL DATE:

☐ **REFER FOR HOME SLEEP APNEA TESTING**

Referral includes the following

- **Level III Home Sleep Test**
- **Auto CPAP Titration following Diagnosis**
- **Sleep Test Referral to Respirologist**

☐ **REFER FOR CPAP THERAPY CONSULT**

Patient was previously diagnosed with Sleep Apnea and uses a PAP machine

Consults can address general therapy or mask concerns, compliance, and current machine pressures and settings

REFERRING PHYSICIAN

Physician Name:

Physician Signature: _____

PHYSICIAN PLEASE FAX REFERRAL TO SASKATOON CPAP SERVICES CLINIC
TESTING COMPLETED BY APPOINTMENT ONLY

PATIENT REFERRAL EXPIRES 10 MONTHS FROM DATE RECEIVED BY SASKATOON CPAP SERVICES
SASKATOON CPAP SERVICES IS A PRIVATE PROVIDER
REFERRAL FORM UPDATED JANUARY 2026