MedSleep

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SLEEP DISORDER REFERRAL FORM *PLEASE FAX THIS FORM TO: (613) 547-9910*

PERSONAL INFORMATION

Name ______________________

OHIP # ______________________

Birth Date ______________________ Age ________

Height ________ Weight ________ Gender: ☐ M ☐ F

Home Phone ______________________

Work Phone ______________________

Street Address ______________________

City ______________________ Postal Code ________

Email ______________________

REFERRING PHYSICIAN

Physician ______________________

Billing # ______________________

Street Address ______________________

City ______________________ Postal Code ________

Phone ______________________

Fax ______________________

Email ______________________

TEST REQUESTED

☐ **CONSULTATION ONLY** ☐ **CONSULTATION, SLEEP STUDIES, AND TREATMENT WHERE APPROPRIATE**

☐ **SLEEP STUDY ONLY** (*Please complete sections 1–5 below*) *OR* ☐ **CONSULTATION AND SLEEP STUDY, IF INDICATED** (*Please complete sections 1–3 below*)

☐ *Has the referred patient had a previous sleep study?* ☐ *Yes* ☐ *No*

☐ *If yes, please provide the date of the last sleep study:* ______________________ *Location:* ______________________

HISTORY AND PHYSICAL INFORMATION

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☐ **ELECTIVE** ☐ **URGENT** If urgent, please explain: ______________________

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❶ HISTORY OF SLEEP PROBLEM

☐ Snoring
☐ Witnessed Apneas
☐ Excessive Daytime Sleepiness
☐ Nocturia
☐ Insomnia
☐ Frequent Awakenings
☐ Restless Legs Syndrome
☐ Periodic Limb Movement Disorder
☐ Shift Work
☐ Cataplexy
☐ Sleepwalking/Nightmares
☐ Other ________

❷ MEDICAL CONDITIONS

☐ MI/CAD
☐ Diabetes
☐ Seizures/Epilepsy
☐ Stroke
☐ GERD
☐ Asthma/COPD
☐ Fibromyalgia
☐ Chronic Pain
☐ Mood Disorder
☐ CHF
☐ Anxiety Disorder
☐ Cardiac Arrhythmia
☐ Hypertension

❸ MEDICATIONS

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❹ DOES THE PATIENT HAVE A SAFETY CRITICAL OCCUPATION?

☐ Yes ☐ No

❺ SPECIAL NEEDS (*i.e., assistance moving, difficulty communicating*)

____

Physician's signature: ______________________ Date: ________

☐ *PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.*