MedSleep

MedSleep Atlantic
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PROFESSIONAL EXPERTISE • COMPREHENSIVE EVALUATION • INTEGRATIVE TREATMENT

SLEEP DISORDER REFERRAL FORM
PLEASE FAX THIS FORM TO: 902-407-4341

TEST REQUESTED - *Please choose one of:*

PLEASE CHOOSE ONE OF:

☐ **APNEA FAST TRACK**™
In-home sleep study followed by APAP therapy for Obstructive Sleep Apnea (OSA) and/or Sleep Medicine consultation as indicated

☐ **IN-CLINIC LEVEL 1 (FULL POLYSOMNOGRAPHIC) SLEEP STUDY** *(not covered by MSI)*

☐ **IN-HOME SLEEP STUDY FOR OSA**

☐ **REQUEST FOR CONSULTATION**
Sleep medicine Consultation and Sleep Testing (as indicated)

PATIENT INFO

Name _____ City / Town _____

Date of Birth _____ Daytime Phone _____
DD/MM/YYYY

Height _____ Weight _____ Evening Phone _____

SYMPTOMS:

☐ Snoring
☐ Insomnia
☐ Witnessed Apneas
☐ Excessive Daytime Fatigue
☐ Excessive Daytime Sleepiness
☐ Restless Legs Syndrome
☐ Other _____

MEDICAL CONDITIONS:

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

COMMENTS / MEDICATIONS:

PHYSICIAN INFO

Physician _____

Phone _____ Fax results to _____

Signature _____ Date _____
DD/MM/YYYY

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For further information on fees please contact us directly.

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